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Conversation Analysis of Michael White's Decentered and Influential Position

by

Dragana Ilic

A Dissertation Presented to the  
College of Arts, Humanities, and Social Sciences  
In Partial Fulfillment of the Requirements for the Degree of  
Doctor of Philosophy

**Nova Southeastern University**

**2017**

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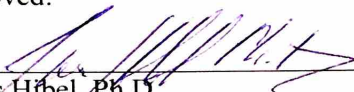
**Nova Southeastern University**

**College of Arts, Humanities, & Social Sciences**

This dissertation was submitted by Dragana Ilic under the direction of the chair of the dissertation committee listed below. It was submitted to the Graduate School of Humanities and Social Sciences and approved in partial fulfillment of the requirements for the degree of Philosophy in the Department of Family Therapy at Nova Southeastern University.

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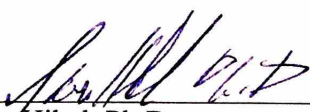
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## **Abstract**

The relationship between the therapist and the client is an important consideration for most models of therapy, with all models of therapy emphasizing the importance of establishing a positive therapeutic relationship. Quantitative and qualitative studies have shown that the relationship between the therapist and the client is a predictor of positive outcomes. However, different models define the preferred therapeutic relationship differently. This study was a qualitative exploration of a decentered and influential position of the therapist in narrative therapy. A video of a one-session narrative therapy case conducted by Michael White was analyzed using conversation analysis to answer the following research question: How, if at all, can White be seen to take a decentered and influential position in narrative therapy? The findings of this study provide more knowledge about White's decentered and influential stance in narrative therapy. It is expected that this knowledge could be useful for education and training purposes, as well as for the improvement of clinical practice.

*Keywords:* decentered and influential, conversation analysis, narrative therapy

## **CHAPTER I: INTRODUCTION**

Research shows that therapeutic alliance is one of the most important factors in successful outcome of therapy regardless of a therapeutic modality used by therapists and clients' presenting problems (Howard & Symonds, 1991; Lambert & Barley, 2001; Martin, Garske, & Davis, 2000). Even though most, if not all, therapeutic approaches emphasize the importance of creating and maintaining a collaborative, positive therapeutic relationship with clients, it is often unclear or insufficiently explained how it is done. Often times, these relational (or joining) clinical skills are assumed to be inborn or sufficiently possessed by therapists prior to any clinical experience versus something that therapists can develop and improve during their clinical experience and training. Therapists in training often hear requests from their supervisors to “go in the room and join” with their clients without really knowing which stance will lead them to the best possible outcomes. Therapists often face an impasse when they are unable to maintain and repair a therapeutic relationship during the course of treatment, and as a result of weak therapeutic alliances, clients are likely to drop out of treatment (Raytek, McCrady, Epstein, & Hirsch, 1999; Robbins, Turner, Alexander, & Perez, 2003; Robbins, et al., 2006; Sharf, Primavera, & Diener, 2010).

The question remains, how to create a positive relationship with clients? What needs to happen for the therapist to create the best possible condition for collaboration and respectful inquiry? How are therapeutic alliances not only initially created, but also maintained from the first session through the course of therapy?

One way to answer these questions is by closely examining the position or the stance of Master therapists who have demonstrated their clinical expertise in constructing

collaborative and respectful therapeutic relationships with their clients. This study focused on a decentered and influential position of Michael White in narrative therapy. More specifically, this study explored and described ways in which Michael White takes a decentered and influential position.

### **Position of the Therapist**

Different therapists may take varying positions in relationship with their clients to achieve preferred outcomes. These different positions may be shaped by different factors. For example, therapists informed by first order cybernetic theories view “families as machines” and “therapists as repair person,” who makes “detached, objective assessments of what is wrong and fix the problems” by designing a strategic interventions to interrupt dysfunctional patterns (Freedman & Combs, 1996, pp. 3-4). In this worldview, a therapist’s position is that of an expert, given that he or she provides wisdom while his or her clients are receiving the expert knowledge without necessarily enhancing their personal agency.

On the other hand, therapists who are informed by second order cybernetic theories view themselves as a part of client-therapist system; they understand that “the environment as we perceive it is our invention” (von Foerster, 1973, p. 1). In other words,

the possibility of objectivity no longer exists for reality is understood as completely self-referential. That is, as we observe, we influence that which we are attempting to understand. Everything we see is filtered through our personal frame of reference and our very presence changes the context...the behavior we observe and the meaning we assign to it are our constructions. (Becvar &

Becvar, 1999, p. 36)

This view acknowledges multiple realities and places even more responsibility on therapists about how they view people and their challenges, and what are the consequences about such views, and requires reflection on how they see their role in therapy and how they situate themselves in the relationship with their clients.

Parry and Doan (1994) stated that, “second-order cybernetics makes it clear that we can never even escape the influence of the perspectives and actions of whatever system we attempt to observe” (p. 24). Acknowledging therapist’s participation in the client-therapist system, Milan Systemic Family Therapy team developed practices, such as circular questions and hypothesizing, which promote therapists’ position in client-therapist system characterized by respecting multiple perspectives and neutrality. According to this theory, “the problem does not exist independently of ‘observing systems’ that are reciprocally and collectively defining the problem” (Boscolo, Cecchin, Hoffman, & Penn, 1987, p. 14) and “the therapists can never know a priori how a family should be” (p. 98).

Therapists operating from lineal epistemology might take an expert position in the relationship with their clients. They would try to find the root cause of the problem because they believe that all problems can be solved if the therapist discovers what causes a person to act in a certain maladaptive way, according to their modern theoretical assumptions. For example, cognitive therapists attempt to change dysfunctional cognitions and irrational beliefs (Beck, 1995; Beck, Rush, Shaw, & Emery, 1979). Psychoanalytically oriented therapists try to bring unconscious conscious by using techniques such as free association and dream analysis, by focusing on resistance and



transference and on restructuring of personality rather than solving immediate problems (Fenichel, 1972; Mitchell & Black, 1995). A position of behavioral therapist is described as a “controlling agent” (Skinner, 1953, p. 369) who aims to eliminate maladaptive or dysfunctional behaviors by operant conditioning.

Different therapists’ position in a relationship with clients can also be influenced by a therapist’s stance with regard to power, gender and culture (e.g., whose knowledge and voice is to be privileged in therapeutic process); their professional code of ethics and abidance to laws; their values, beliefs, biases, and previous experiences; their perception of people who seek their consultation (e.g., dysfunctional/functional, abnormal/normal, healthy/unhealthy, etc.); or their conceptualization of clients’ problems that are based on their model of therapy.

Therapists who are informed by narrative metaphor and social constructionist worldview are guided by the following assumptions, “1) Realities are socially constructed, 2) Realities are constructed through language, 3) Realities are organized and maintained through narrative, and 4) There are no essential truths.” (Freedman & Combs, 1996, p. 22). These therapists listen and respect multiple realities, explore dominant stories that have an oppressive or limiting effect for clients, privilege client(s) voice, focus on meaning instead of facts, ask clients to evaluate their problems and therapy and to take a position, and are reflective, transparent, and collaborative (Freedman & Combs).

This study utilized one particular template to explore the therapist’s position in a relationship with the client. White (2005) proposed a two by two matrix, which details four different therapeutic positions presented in the figure 1 below.

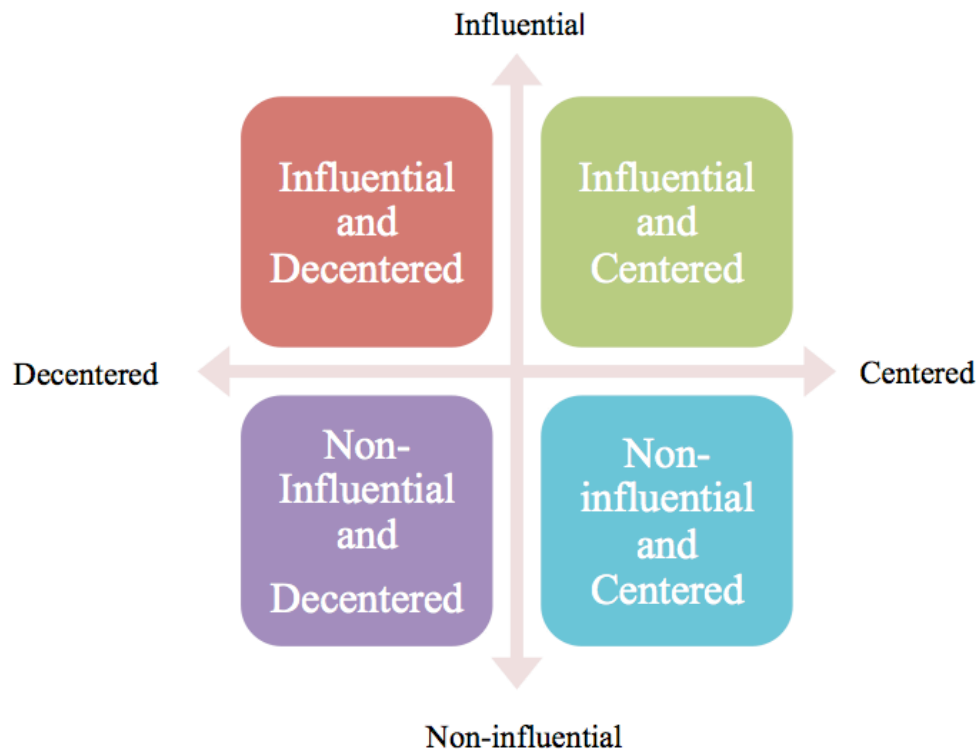


Figure 1. Michael White's Model of Different Positions of the Therapist

The x axis of the matrix distinguishes between a therapeutic position which is centered versus decentered. A centered therapeutic position places the therapist at the center of the therapeutic interaction, whereas a decentered therapeutic position places the client(s) at the center of the therapeutic interaction. For example, a *decentered* therapeutic position is one in which “the therapist is not the author of people’s positions on the problems and predicaments of their lives” (White, 2007, p. 39). Rather, the client’s voice is privileged over the therapist’s expert knowledge.

A decentered position may be characterized by a not-knowing, curious, and respectful attitude in which therapists do not assume that they know the meaning of clients’ problems, what is important to them, and how they should live their lives. Rather, clients are invited to categorize and reflect on their experiences, and to take their

own stance how they prefer to live their lives. As a result of such inquiry, clients may experience “personal agency and the capacity for responsible action” (White, 2007, p. 289) and they may feel empowered “to pursue what is precious to them” (p. 59).

Therefore, a decentered position of the therapist is likely to create opportunities in conversation for more in-depth exploration of clients’ problems in relation to their preferences, which is usually different from what our clients experience in their lives. Often, our clients “have been simply subject to the meanings given and the position taken by others on developments of their lives” (White, 2007, p. 220).

People tend to judge themselves and others based on a contemporary cultural norms for what it means to be a “real” person, worthy, successful, normal, healthy, and so forth (White, 2002). In other words, “there is nothing in the mind that is not first in society” (Gergen, 2009, p. 92). Often, people try to achieve the qualities that are highly valued by their culture, and any perceived deviation can lead to self-criticism; feelings of inadequacy, personal failure, a sense of not being good enough, a sense of guilt, and exercising more self-control in order to become a better and more worthy person (Maisel, Epston, & Borden, 2004). A decentered position of the therapist helps in deconstructing and unmasking those cultural ideas and their role in clients’ predicaments.

In a centered position therapists take an expert role by diagnosing, intervening, and treating people based on their predetermined assumptions what would be the best cure for client(s) (e.g., changing their irrational thoughts, setting clear boundaries, enhancing differentiation of self). White (2007) believes that “when the therapist takes authorship in this way, the door closes on collaboration, and therapist is set up to feel burdened and exhausted while the people who are seeking consultation feel impotent” (p.

40). In addition, “when therapists do assume primary authorship in this way, it is common for them to enter into a ‘convincing mode’ in which their responses are primarily limited to giving affirmations, pointing out positives, and making attempts at reframing” (p. 233). This stance is characterized by modernist perspective or “positive explanation” of the world and assumes existence of therapists’ objectivity.

The y axis distinguishes between a position in which the therapist is influential versus a position in which the therapist is relatively non-influential. An influential therapist views their role as more active in stimulating the conditions for change and takes responsibility for enacting those conditions. White (2005) stated:

The therapist is influential not in the sense of imposing an agenda or in the sense of delivering interventions, but in the sense of building a scaffold, through questions and reflections, that makes it possible for people to: a) more richly describe the alternative stories of their lives, b) step into and to explore some of the neglected territories of their lives, and to c) become more significantly acquainted with the knowledges and skills of their lives that are relevant to addressing the concerns, predicaments and problems that are at hand. (p. 9)

On the other hand, a non-influential therapist sees himself or herself in a more conversational role, which incorporates non-directive responses to client statements. Examples of decentered and non-influential position can be found, for example, in collaborative language systems therapy in which “the therapist does not control the interview by influencing the conversation toward particular direction in the sense of content or outcome, nor is the therapist responsible for the direction of change” (Anderson & Goolishian, 1988, p. 385). Rather, the therapist, through dialogue,

collaborates with clients in order to understand them and “to involve oneself in the coevolution of understanding and meaning” (p. 385).

Therapists are active participants in therapeutic conversations and have a responsibility for creating conditions for preferred outcomes. “How therapists respond to people’s stories is critically important” (Duvall & Beres, 2011, p. 35). How they select and interpret what they hear, what they see or what they don’t see, and how they use knowledge and prioritize, it all has consequences in what might develop in a therapeutic conversation. Bateson (1972) in interpreting Kant stated that, “the most elementary aesthetic act is the selection of a fact” (p. 459). Depending on what they select and how therapists respond to clients’ stories, therapists may find themselves being useful to perpetuating clients’ problems or to even causing harm (e.g., re-traumatizing), which also inevitably affects their relationships. Gale (1996) explained that, “an individual’s action is not independent of the actions of others but is patterned in relationship to others’ actions” (p. 109).

Given that a therapist is a part of a therapist-client system, according to second order cybernetics, and that his or her role is to create positive relationships with his or her clients, it would be useful to explore in more depth a therapeutic conversation by looking at the position of the therapist. This study is focused on exploring a decentered and influential position, which is used in narrative therapy. However, this position is not limited to narrative therapists; it can be also used in other treatment modalities. It is not intention of this study to claim that this is the only useful stance in therapeutic conversation, but, rather, to discover how Michael White uses a decentered and influential position in his performance of narrative therapy with a family.

### **Research question**

This qualitative research study addressed the following question: How, if at all, can Michael White be seen to take a decentered and influential position in narrative therapy?

### **Purpose of Current Study**

The purpose of this study is to explore and better understand the performance of the decentered and influential position of the therapist in narrative therapy by studying Michael White's talk. This study provides more details about different ways in which White can be observed to use a decentered and influential position. My decision to explore a decentered and influential position of the therapist is based on lack of research in this area, since creating and maintaining a positive client-therapist relationship or therapeutic alliance is an important factor in the successful outcome of therapy, regardless of a therapeutic modality used by therapists, and clients' presenting problems (Howard & Symonds, 1991; Lambert & Barley, 2001; Martin, Garske, & Davis, 2000). It is my clinical experience that this stance has a potential to create profoundly positive relationships with clients, which in turn led to positive outcomes.

The findings of this research may expand the scope and depth of knowledge in understanding how to relate with clients taking a decentered and influential position by providing the data that is rich in details. This knowledge could also help marriage and family therapists in training learn how to practice a decentered and influential position in order to establish positive relationships with clients and possibly avoid burnout (White, 2007).

I utilized a video recorded narrative therapy session conducted by Michael White consulting with a family and conducted a conversation analysis (CA) to answer the research question. White's video narrative therapy session was used because he invented the idea of a decentered but influential position.

For the purposes of this study, I used conversational analysis (CA) method of qualitative analysis. CA is a useful research method for studying how relationships and identities are created through language, which is consistent with social constructionism and second-order cybernetics (Gale, 1996). Gale stated that,

CA is a qualitative research method that is inductive, discovery-oriented, and concerned with process (the "how" question); analyzes participants' displayed understandings of interactions; and is iterative. There is continuous recursion between listening to segments of the talk, transcribing the segments, developing categories of patterns, and comparing these categories with subsequent segments of talk. (pp. 111-112)

### **Conclusion**

In this chapter, I introduced the current study. In Chapter 2, I critically examine and discuss the most recent relevant literature related to the research question. In Chapter 3, I present the details of the research process. The methodology section includes the following: selecting data, data collection, self-of the researcher, data analysis, and trustworthiness of the method. Chapter 4 will present detailed data analysis of short segments from the transcript of therapeutic conversation. Lastly, in chapter 5 I will reflect upon completed research and discuss implications of the study, future directions for research, and limitations of this study.

## **CHAPTER II: REVIEW OF THE LITTERATURE**

In this chapter, I examine the existing literature that is relevant to this study's research questions. In the first part of the literature review, I explore different positions of the therapist in the therapeutic relationship with clients based on different linear and systemic psychotherapy approaches in counseling and marriage and family therapy field. In the second part of this chapter, I review findings of outcome research studies on therapeutic alliance and specific presenting problems. Finally, narrative therapy practices and assumptions are presented related to the position of the therapist in narrative therapy.

### **Part One: Therapeutic Relationships**

#### **Psychoanalysis**

The relationships between therapists and clients have been scientifically studied since the time of Sigmund Freud's psychoanalytic psychology in which he developed the concepts of transference, resistance, and countertransference (Horvath, 2001). Freud believed that the patient's defense mechanisms block his or her repressed secrets, childhood memories, and unconscious wishes and that through free association those repressed feelings and thoughts can be analyzed (Mitchell & Black, 1995). Freud also believed that in a therapeutic relationship through the process called transference, patients project their conflictual feelings and thoughts, that constitute their difficulties, onto the analyst, who is then their object of love, longing or/and hate (Mitchell & Black, 1995). Freud (1917) defined the concept of transference in the following terms:

We mean a transference of feelings on to the person of the doctor since we do not believe that the situation in the treatment could justify the development of such feelings. We suspect, on the contrary, that the whole readiness for these feelings is



derived from elsewhere, that they were already prepared in the patient and, upon the opportunity offered by the analytic treatment, are transferred on to the person of the doctor. (p. 442)

What this means is that what happens in the relationship between the therapist and the client is a result of the clients' unconscious projection of their repressed psychic memories that are triggered in relationship with a therapist in which clients' react to therapists as they would to some other significant figure (e.g., their parent) from their past. Freud (1912) believed that "the patient will wave the figure of the physician into one of the 'series' already constructed in his mind" (p. 107) and the patient's intense feelings of affection or/and hostility toward the therapist is "justified neither by the doctor's behavior nor by the situation that has developed during the treatment" (Freud, 1917, p. 440). It appears that clients' attitude toward the therapist has little or nothing to do with the therapist's actions toward them in their relationship.

Freud argued that, "the resolution of transference is synonymous with the resolution of neurosis" (as cited in Bauer, 1994, p. 23). Hence, the main focus of psychoanalysis in creating therapeutic change lies in analysis of transference and the analysis of resistance (the impediments to free association) (Mitchell & Black, 1995). Freud (1917) suggested:

We overcome the transference by pointing out to that his feelings do not arise from the present situation and do not apply to the person of the doctor, but that they are repeating something that happened to him earlier. In this way we oblige him to transform his repetition into a memory. By that means the transference, which, whether affectionate or hostile, seemed in every case to constitute the

greatest threat to the treatment, becomes its best tool, by whose help the most secret compartments of mental life can be opened. (pp. 443-444)

Thus, Freud believed that therapist's influence lies essentially on their suggestion in the process of transference and that patients can be cured when they become conscious of what is unconscious and when their repressions are lifted (Freud, 1917). According to White's matrix on position of the therapist (as described in chapter I), the psychoanalytic therapists could be categorized as using a centered and influential position in the therapeutic relationship because they provide an expert interpretation of clients' transference and resistance.

Freud acknowledged in his theory that the therapist can project his or her unfinished business onto their clients if their clients evoke in them negative emotional reactions, which he called countertransference. He believed that in order to prevent countertransference, analysis of the therapist's unfinished business/psyche is needed (Horvath, 2001). It is assumed that by preventing countertransference, the therapist will be objective, neutral, and empathetic (Horvath, 2001), which is required for effective performance of psychodynamic therapy.

The psychotherapists who were influenced by Freud and stimulus response learning theory such as Dollard and Miller (1950) view the etiology of symptoms and therapeutic relationship in the following way:

If neurotic behavior is learned, it should be unlearned by some combination of the principles by which it was taught. We believe this to be the case. Psychotherapy establishes a set of conditions by which neurotic habits may be unlearned and non-neurotic habits learned. Therefore, we view the therapist as a kind of teacher

and the patient as a learner. In the same way and by the same principles that bad tennis habits can be corrected by a good coach, so bad mental and emotional habits can be corrected by a psychotherapist. (pp. 7-8)

More specifically in this learning process, in which clients are also supposed to achieve insight, Dollard and Miller (1950) described the position of the therapist in the following way:

The therapist shows exceptional permissiveness; he encourages the patient to express feelings in speech (but not in direct action) in the therapeutic situation. He does not condemn and is exceptionally able to tolerate the discussion of matters that have caused the patient's friends to show anxiety or disgust. The therapist's composure tends to be imitated by the anxious patient and thus has a reassuring effect. When the patient has always received severe disapproval, the therapist's calm accepting silence is experienced as a great relief and a striking intervention. In addition to the permitting free speech, the therapist commands the patient to say everything that comes to mind. By free association technique the therapists sets the patient free from the restraint of logic. The therapist avoids arousing additional anxiety by not cross-questioning. By encouraging the patient to talk and consistently failing to punish him, the therapist creates a social situation that is exact the opposite of the one originally responsible for attaching strong fears to talking and thinking. The patient talks about frightening topics. Since he is not punished, his fears are extinguished. (p. 230)

## **Behaviorism**

Behavioral therapists influenced by Skinner's operant conditioning, Pavlov's classical conditioning, and Bandura's social learning theory believe that the positive therapeutic relationship is necessary for increasing compliance with treatment and for effective use of techniques, but not sufficient in itself for change in clients' behavior (Corey, 2005). The main role of the therapist is to teach clients new skills through the provision of instruction, modeling, and giving feedback and homework assignments. In behavioral therapy, "therapists use behavioral techniques to change relevant current factors that are influencing the client's behaviors" (Corey, 2005, p. 232). Behavioral therapists are active and directive, acting as consultants and problem solvers. The clients are expected to be active and motivated to change; they are asked to learn self-management strategies and to continue performing learned behavior or strategies from the session to their everyday life (Corey, 2005).

Unlike Freud, Skinner believed that "a concept of self is not essential in an analysis of behavior" (Skinner, 1953, p. 285). He said that, "If we cannot show what is responsible for man's behavior, we say that he himself is responsible for it... Whatever the self may be, it is apparently not identical with the physical organism. The organism behaves, while the self initiates or directs behavior. Moreover, more than one self is needed to explain the behavior of the organism." (Skinner, 1953, pp. 283-284). Thus, people have many selves and personalities or a "system of responses" (p. 285) shaped by reinforcements and punishments from their environment. "The concept of self may have an early advantage in representing a relatively coherent responsive system, but it may

lead us to expect consistencies and functional integrities which do not exist.” (Skinner 1953, p. 286).

The therapist’s position in behavioral therapy is that of a “controlling agent” (Skinner, 1953, p. 369) who initially has little power and needs to make sure that clients will come back to treatment. As his or her power increases during the treatment, the therapist becomes a source of reinforcement by providing positive reinforcements and also acts as a “nonpunishing audience” (p. 370) by avoiding punishments and objections. Skinner believed that “the appearance of previously punished behavior in the presence of a nonpunishing audience makes possible the extinction of some of the effects of punishment...The patient feels less wrong, less guilty, or less sinful” (p. 371). Hence, although behavioral therapists believe that a relationship with a client is not enough for change, they influence it by taking a stance in which they are avoiding punishments and providing reinforcements for what they select is important. These actions could be described as a centered and influential position as described by Michael White (2007).

### **Cognitive Therapy**

Beck’s cognitive therapy is based on underlying assumptions that problems and psychological disorders are caused by illogical thinking, distortions of reality (e.g., as evident in paranoia and neuroses), and faulty information processing such as arbitrary inference, selective abstraction, overgeneralization, magnification and minimization, personalization, and absolutistic, dichotomous thinking (Beck, 1979; Beck, 1995; Beck, Rush, Shaw, & Emery, 1979). The role of the therapist is “to be able to empathize with the patient’s painful emotional experiences as well as to be able to identify his faulty cognitions and the linkage between negative thoughts and negative feelings” (Beck et al.,

1979, p. 35). The main assumption of this model is that changes in cognition will cause change in how the client feels and behaves. Furthermore, “therapeutic change is a result of clients confronting faulty beliefs with contradictory evidence that they have gathered and evaluated.” (Corey, 2005, p. 286).

Beck (1979) stressed that therapeutic collaboration is crucial for positive outcome of cognitive therapy. Rapport or “harmonious accord between people” (p. 51) is established when the client sees the therapist as someone,

- a) who is tuned in to his feelings and attitudes, b) who is sympathetic, empathic, and understanding, c) who is accepting of him with all his “faults,” d) with whom he can communicate without having to spell out his feelings and attitudes in detail or to qualify what he says. (Beck et al., 1979, p. 51)

On the other hand, Beck et al. (1979) suggested that, “there is no standard set of behaviors that will induce a sense of rapport with the patient” (p. 52). Different responses and styles, for example, serious and detached or friendly and warm, would be more or less helpful for different clients in establishing rapport. How is that determined, Beck did not define. Regardless of that, cognitive therapists might be considered as taking a centered and influential position by applying their model of therapy.

### **Cognitive Behavior Therapy**

In Ellis’s Rational Emotive Behavior therapy (REBT), therapist is a teacher who is often directive, persuasive, and confrontative (Corey, 2005). Both Beck and Ellis believe that clients have irrational thoughts; however, Ellis tried to persuade his clients that some of their thoughts are dysfunctional and irrational whereas Beck used more of a Socratic questioning to achieve the same. In addition, Ellis did not believe that a warm

relationship with clients is essential for a significant therapeutic effect (Ellis, 2003). On the contrary, contradicting clients based on their presented evidence, not hesitating to give their view, being one step ahead of a client, not being too sympathetic toward clients' feelings, using strong language are some of the things therapists try to do (Ellis, 2011) in their assisting clients.

The underlying assumption of REBT is that emotional problems are the consequence of clients' unrealistic and illogical thinking (e.g., their "musts," "shoulds") as well as their judgments of themselves based on their performance, in other words, their self-defeating beliefs (Ellis, 2011). An event in itself does not lead to emotional problems, rather, the client's belief system does. Thus, clients are responsible for their problems and the goal of therapy is to change their irrational beliefs and help them achieve the unconditional self-acceptance, unconditional other acceptance, and unconditional life acceptance (Ellis, 2005). In addition, "REBT tends to teach clients rational and helpful behaviors" (Ellis, 2011, p. 198). Ellis (1976) criticized Freud's and others idea of "ego" by saying that it has negative evaluating effects on people's lives.

The self-rating aspects of ego, in other words, tend to do you in, to handicap you, to interfere with your satisfactions. They differ enormously from the self-individuating aspects of ego. The latter involve how or how well you exist. You remain alive as a distinct, different, unique individual because you have various traits and performances and because you enjoy their fruits. But you have "ego" in the sense of self-rating because you magically think in terms of upping or downing, deifying or devil-ifying yourself for how or how well you exist. Ironically, you think that rating yourself, your "ego," will help you live as a

unique person and enjoy yourself. Well, it won't! For the most part it will let you survive, perhaps—but pretty miserably! (Ellis, 1976, p. 345)

Given that the therapist is a teacher and a client is a student learning A-B-C model of changing his or her cognition (Corey, 2005), REBT therapists can be categorized as taking a centered and influential position in the therapeutic relationship with their clients.

### **Humanism and Existentialism**

Humanistic and existentialist movements had influenced a development of several models of psychotherapy, such as Roger's client-centered therapy, Perls's gestalt therapy, Frankl's logotherapy, among others. Humanism and existentialism both emphasize concepts such as choice, values, personal responsibility, autonomy, meaning, and purpose and believe that clients can make positive and constructive choices (Corey, 2005). They differ in that, "existentialists take a position that we are faced with the anxiety of choosing to create an identity in a world that lacks intrinsic meaning...(while) the humanists...take somewhat less anxiety-evoking position that each of us has a natural potential that we can actualize and through which we can find meaning." (Corey, 2005, p. 166) Moving away from psychoanalysis and behaviorism, existentialism and humanism were considered a third force in therapy in 1960s and 1970s. The position of the therapist in models influenced by humanism and existentialism also differs from those in psychoanalytic, behavioral, and cognitive models of therapy.

### **Client-centered Therapy**

Carl Rogers, who developed a client-centered model of psychotherapy, was interested in therapeutic alliance, more specifically, elements and conditions in psychotherapy that initiate constructive personality change (Rogers, 1957). Rogers



believed that providing a special relationship to clients is necessary and sufficient for therapeutic change to occur (Rogers, 1957). This therapeutic relationship is characterized by the therapist's genuineness in the relationship, his or her high degree of unconditional positive regard, which includes acceptance and caring for the client, the therapist's accurate empathic understanding of the client's experience, and the client's perception of the therapist's acceptance and empathy for him or her. Rogers (1957) stated that this kind of relationship could be found in good friendships as well; however, the positive regard often becomes conditional. Rogers (1957) also believed that "diagnostic knowledge is not essential to psychotherapy" (pp. 101-102) and that therapists don't need intellectual professional knowledge to be effective. His theory sees no essential value in interventions such as analysis of transference, free association, interpretation of personality dynamics, and so forth (Rogers, 1957).

Rogers had a significant influence on the practice of psychotherapy (Friedman & Schustack, 2003). He believed that "it is the client and not the therapist who best understands where the problems are and in what directions therapy should proceed" and he "viewed a person as a process – a changing constellation of potentialities, not a fixed quality of traits" (p. 317). However, he believed that the role of the therapist is to reflect back to client his or her incongruent feelings, and to help them become more mature and self-integrated (Friedman & Schustack, 2003). Rogerian therapists tend to be non-influential (non-directive) and relatively centered since they operate with a normative idea that clients should become more self-congruent and integrated, although what it means for each client might be different.

## **Gestalt Therapy**

While Freud was focused on examining unfinished business from childhood that is repressed and constitutes intrapsychic conflicts, Perls's Gestalt therapy focuses on here-and-now experiences of clients (how they behave now) rather than abstract talking about situations (why they behave as they do) (Corey, 2005). This approach to therapy is more experiential and promotes increase in self-awareness. For example, instead of talking about childhood trauma with a father, the therapist will ask the client to act as a hurt child and to speak to his or her father in an empty chair technique experiment as if the father were in the room. Perls believes that,

No individual is self-sufficient; the individual can exist only in an environmental field. The individual is inevitably, at every moment, a part of some field, which includes both him and his environment. The nature of the relationship between him and his environment determines the human being's behaviour. With this new outlook, the environment and the organism stand in a relationship of mutuality to one another. (as cited in Kepner, 1980, p. 2)

Perls also believes that "clients have to grow up, stand on their own two feet, and deal with their life problems themselves" (as cited in Corey, 2005, p. 193).

In contrast to Perls's way of working, contemporary Gestalt therapy stresses dialogue between client and therapist. The therapist has no agenda, no desire to get anywhere, and understands that the essential nature of the individual's relationship with environment is interdependence, not independence. (Corey, 2005, p. 193)

Gestalt therapists pay attention to clients' body language and use of language (e.g., their metaphors, language that denies power, language that uncovers a story), assist clients in increasing their self-awareness in present moment, create atmosphere in which clients can try new behaviors and new ways of being (Corey, 2005). They "do not force change on clients through confrontation. Instead, they work within a context of I/Thou dialogue in a here-and-now framework" (Corey, 2005, p. 200). They also emphasize the quality of the therapist's presence. Perls (1976) suggested that the person of the therapist is more important than his or her techniques:

A Gestalt therapist does not use techniques; he applies himself in and to a situation with whatever professional skill and life experience he has accumulated and integrated. There are as many styles as there are therapists and clients who discover themselves and each other and together invent their relationship. (p. 223)

Gestalt therapists are "willing to express their reactions and observations, they share their personal experience and stories in relevant and appropriate ways, and they do not manipulate clients" (Corey, 2005, p. 204).

The overriding aim of therapy as I see it is not simply to cure people (whatever "cure" may mean), nor is it to teach clients how to become more adept at manipulating the environment rather than themselves. Nor is the goal to enable each individual to develop a more differentiated and integrated self. It may be all of the above but the essential aim is to assist in the evolution of a self which can ultimately transcend the self. This means that at the core of personal development there is this central polarity: freedom and liberation on the one hand, and discipline and social responsibility on the other. It is the tension between these

opposites which permeates everything we do. (Kepner, 1980, p. 10)

Given that Gestalt therapists emphasize being aware and living in a present moment as well as identifying and working on “unfinished business from the past that interferes with current functioning” (Corey, 2005, p. 478), it seems that Gestalt therapists take a centered and relatively non-influential position in their work with clients.

### **Adlerian Individual Psychology**

Alfred Adler, a founder of Individual psychology, believed that “we cannot think, feel, will, or act without the perception of some goal (Adler, 1924, p. 3). He stated,

Let me observe that if I know the goal of a person I know in a general way what will happen. I am in a position to bring into their proper order each of the successive movements made, to view them in their connections, to correct them and to make, where necessary, the required adaptations for my approximate psychological knowledge of these associations. If I am acquainted only with the causes, know only the reflexes, the reaction-times, the ability to repeat and such facts, I am aware of nothing that actually takes place in the soul of the man.

We must remember that the person under observation would not know what to do with himself were he not oriented toward some goal. (Adler, 1924, p. 3)

Thus, individual psychologists believe that “every psychic phenomenon, if it is to give us any understanding of a person, can only be grasped and understood if regarded as a preparation of some goal.” (Adler, 1924, p. 4) Adler also believed that “the psyche has its objective the goal of superiority” (p. 7) which is the main goal of every individual.

While Freud emphasized sexuality and aggression as motivational forces that drive human behavior, Adler saw people as motivated by social influences and success.

Adler also rejected Freud's idea of division of personality into parts such as ego, superego, and id, because he believed that people are unitary organisms adopting holistic idea that "the total is greater than the sum of its parts" (Manaster & Corsini, 2009, p. 3). Individual psychology takes a relational view by looking at individuals' social integration and concern. Because "we gain our standards from others; we do things because of others; and our lives are fully related to others...individuals cannot be studied in isolation" (Manaster & Corsini, 2009, p. 7). In addition, according to Adlerian theory, "healthy individuals are genuinely concerned about other people and have a goal of success that encompasses the well-being of all people" (Mangold, 2013, p. 4). On the other hand, "psychopathology results from lack of courage, exaggerated feelings of inferiority, and underdeveloped social interest" (p. 9). "Feelings of inferiority are common, normal, and functional, in that they serve as motivators to movement, but the direction taken as a result of suffering from inferiority feelings determines whether the subsequent behavior is useful or useless." (Manaster & Corsini, 2009, p. 15). Adler (1964) claimed that,

the origin of every neurosis is shown to lie in the individual goal of superiority always conditioned by painful life experiences of inferiority. The neurotic likes to consider himself a tragic hero in the human situation. The work of the therapist is to show the patient what he is actually doing and to transfer his egocentric interest to social activities and a useful life.

Adler was active and directive in therapeutic style and therapeutic relationship is considered important in "reawakening social interest" (Mangold, 2013, p. 9). One of the goals of therapy is to understand people's motives, who they are and what they are after

(Manaster & Corsini, 2009). “The main aim of therapy is to develop sense of belonging and to assist in the adoption of behaviors and processes characterized by community feeling and social interest” (Corey, 2005, p. 100).

Adlerian therapists are assisting clients by identifying and correcting basic mistakes and faulty assumptions in their thinking such as: selfishness, lack of confidence, mistrusts, and unrealistic ambitions. They collaborate with clients in setting mutually agreed upon goals for therapy; they make comprehensive assessment of their functioning using family constellation questionnaire and early recollection diagnostic tool which explores how clients perceive themselves and others and how they see their future; they encourage self-understanding and provide insight; and they help with reorientation or reeducation of the clients in which “clients are encouraged to recognize that they are in charge of their own lives and can make different choices based on new understandings” (Corey, 2006, p. 111).

The relationship between the therapist and the client is not sufficient for change, but is considered “the foundation for facilitating change” (Bitter & Nicoll, 2000, p. 9). Even though Adlerian therapists try to establish egalitarian relationships with their clients by setting mutually agreed upon goals and collaborating during the process of therapy, they also take centered and influential position by acting as experts with ideas what needs to happen for an individual to be cured (e.g., changing their life goals, faulty assumptions, private logic, basic mistakes, lack of courage, etc.). Adler (1924) also said that, “Individual psychologists are in a position, if a proper procedure is observed, to get a clear conception of the fundamental psychic error of the patient at the first consultation. And the way to a cure is thus open” (vi).

### **Family Therapy Models**

Cybernetic family therapy models had moved away from the linear, cause and effect way of thinking that is predominant in the field of psychology, and which states that the clients' problems can be solved if we understand the root causes of them by objectively investigating clients' histories (Becvar & Becvar, 2006). Family therapy models pay more attention to understanding how human behavior makes sense in their context by looking at interactional patterns, recursion, reciprocity, and shared responsibility in relationships and by assuming that individuals cannot be understood in isolation.

Systemic approaches in family therapy field can be divided into those that are mainly influenced by: a) cybernetics or work of Gregory Bateson (e.g., MRI, Milan Systemic, and Strategic Haley and Madanes), b) psychoanalysis (e.g., Ackerman, Object Relations, Bowenian, and Contextual), and c) von Bertalanffy general systems theory (e.g., Minuchin's structural therapy). More recent family therapy approaches such as solution-focused brief therapy, narrative therapy, and collaborative language systems therapy are influenced by postmodernism and social constructionism.

The position of marriage and family therapists in relationship with their clients differs depending on their theoretical assumptions and their focus in therapeutic process, which is also influenced by guiding metaphors such as "systems," "structure," and "narrative" metaphors that organize therapists' clinical work (Freedman & Combs, 1996). Freedman and Combs (1996) explained how in therapy with our clients "the metaphor through which we organize our work have a powerful influence on both what we perceive and what we do" (p. 1).

### **Mental Research Institute (MRI)**

The MRI group moved away from Freudian theory that saw family as a source of psychic injury to looking at interactional patterns (Hoffman, 2002), which implies less blaming and less believing in individual deficits. The MRI therapy views “problem behavior not in isolation but in relation to its immediate context” (Fisch, Weakland, & Segal, 1982, p. 8). What this means is that it is not possible to understand behavior without looking at the context; each person’s behavior is maintained or changed by another person’s behavior in social interaction; and thus, “one cannot not communicate” (Watzlawick, Beavin, & Jackson, 1967).

Moreover, to constitute a problem, a behavior must be performed repeatedly. A single event may have unfortunate or even disastrous consequences, but the event cannot itself be a problem, since a problem by our definition is an ongoing difficulty...(therefore) people’s attempted “solutions,” the very ways they are trying to alter a problem, contributes most to the problem’s maintenance or exacerbation. (Fisch, Weakland, & Segal, 1982, pp. 12-13)

Thus, MRI therapists believe that problems are maintained in recursive feedback loops of patterns of communication in which people try ineffectively to fix their problem.

MRI therapists take a centered and influential position given that “the therapist’s task is not just to understand the family system and the place of the problem within it but also to take action to change the malfunctioning system in order to resolve the problem.” (Fisch, Weakland, & Segal, 1982, p. 9). This model aims to assist people in getting unstuck from the interactional cycle of ineffective handling of problems by designing strategic interventions. Fisch et al., stated that,



The therapist must be an active agent of change. Not only must he get a clear view of the problem behavior and of the behaviors that function to maintain it; he must also consider what the most strategic change in the 'solution' might be and take steps to instigate these changes." (p. 19)

Fisch et al. (1982) believe that "the client is not in a position to know how his problem should best be approached" (p. 22). Therefore, it is the therapist's job to convince family members to apply strategic interventions designed by the therapist. Given that the therapist is an expert who is supposed to intervene in a family system, the great emphasis in this model of therapy is placed on ways to enhance maneuverability of therapist (Fisch et al.) and "selling" the task or intervention. Some of the tactics that provide therapists control over the treatment include "taking one's time," "timing and pacing," "getting the client to be specific," "one-downsmanship," focusing on behavioral description of current problem, "who is doing what that presents a problem, to whom, and how does such behavior constitute a problem" (p. 70), and interventions such as "go slow," "the dangers of improvement," and other paradoxical interventions. The positive outcome of MRI model represents "the client's report that he has been able to do something he had not been able to do while enmeshed in the problem" (p. 124). MRI therapists could be described as taking a centered and influential position according to Michael White.

### **Milan Systemic Family Therapy**

Boscolo, Cecchin, Selvini Palazzoli and Pratta developed Milan systemic family therapy after studying Gregory Bateson and MRI's ideas (Boscolo, Cecchin, Hoffman, & Penn, 1987). Milan systemic family therapy evolved over time from more strategic stance of a therapist to taking a "neutral" stance in interaction with clients with a use of

circular questioning and hypothesizing (Boscolo et al., 1987). However, the main, initial assumptions of this approach include that families are involved in “unacknowledged family games” in which “family members try to unliterary control each other’s behaviors” and therefore, “the task of the therapist is to discover and interrupt these games” (Boscolo et al., 1987, p. 6). The family games are described as a vicious cycle in which no one can clearly win or lose. Some of the interventions used by therapists to intervene are positive connotation, rituals, invariant prescription, and paradoxical interventions.

Milan systemic family therapy is a team approach that involves a structured interview sessions with a team behind the mirror. Sessions may be long and spread over several weeks due to “longer time period needed for a family system to show evidence of change” (Boscolo et al., 1987, p. 5). Initially, team included two male-female couples, one interviewing the family and one couple observing behind the mirror. Later, Milan practice changed into only one therapist interviewing the family. The interview with a family includes five stages: a) the pre-session during which the team discusses and comes up with initial hypothesis about family’s presenting problem, b) the session in which therapists will test and modify their hypothesis, c) the inter-session or team consultation break during which therapists meet with their team to discuss their hypothesis and come up with intervention, d) the intervention stage during which the therapist delivers intervention, and e) the post-session discussion in which team discusses family’s reactions to their intervention and formulates plan for the next session. (Boscolo et al., 1987).

The position of the therapist in this approach is influenced by three main concepts: hypothesizing, circularity, and neutrality. A therapist’s hypothesis is based on

information about the family and their presenting problem obtained prior to the first session and presents a starting point in therapist's investigation. The therapist asks questions and listens to verify the validity of his or her hypothesis. If the initial hypothesis is false, the therapist will form a new hypothesis. "The essential function of the hypothesis consists therefore in the guide it furnishes to new information, by which it will be confirmed, refuted, or modified." (Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1980, p. 2). The therapists also must come up with systemic hypothesis that "account for all the elements in a problem situation and how they link together" (Boscolo et al., 1987, p. 10). The hypothesis is based on how problem is connected to: each family member, to extended system, or/and to therapeutic or referring system.

The concept of circularity is most evident in Milan therapists' technique of circular questioning, which is used to scan for difference. Selvini-Palazzoli et al. (1980) explained that "by circularity we mean the capacity of the therapist to conduct his investigation on the basis of feedback from the family in response to the information he solicits about relationships and therefore about difference and change" (p. 3). There are several categories of circular questions: questions about differences in perception of relationship, now and then questions, questions about differences of degree, hypothetical and future differences, etc. Selvini-Palazzoli et al. (1980) suggested that,

In fact, by formally inviting one member of the family to metacommunicate about the relationship of the two others, in their presence, we are not only breaking one of the ubiquitous rules of dysfunctional families, but we are also conforming to the first axiom of the pragmatics of human communication: In a situation of

interaction, the various participants, try as they might, cannot avoid communicating. (p. 4)

In addition to scanning for differences and verifying and adjusting hypothesis, circular questions are used to investigate “how each member of the family reacts to the symptom” (p. 6) and then how other family members react to that reaction.

Neutrality is third major guideline in performance of Milan systemic therapy (Selvini-Palazzoli et al. 1980) that shapes therapeutic posture. Boscolo et al. (1987) explained that what they mean by neutrality is “closer to multipositional than nonpositional” (p. 11) stance. The evidence of neutrality, as described by Milan group, is uncertainty from family members about on whose side was the therapist during the session. The therapist alliance shifts from one family member to another during the session as he or she asks another circular question. “The end result of the successive alliances is that the therapist is allied with everyone and no one at the same time.” (Selvini-Palazzoli et al., 1980, p. 6). Boscolo et al. (1987) explained neutrality as the following position of the therapist:

The therapist accepts family’s solutions as the only ones possible, logical, and congruent for the family at this moment...the therapist can never know a priori how a family should be, the therapist must act as a stimulus, a perturbation that activates the families capacity to generate its owns solutions. In a sense neutral position presents a double message to the family. It says the solution they have found has been perfect until now, but from this moment on they have entered into another interaction (the therapy) that will allow the therapist and the family to

invent together other possibilities from which new solutions may arise. (pp. 97-98)

In addition, Boscolo et al. (1987) said that when therapist is in neutral position, he or she is “free from family’s labels of good and bad...Therapist must view these labels as family attributes to be curious about, interested in, but not as facts to be believed. In this sense, neutrality operates as opposite of morality” (p. 98). Taking a neutral stance, according to Milan group, also means observing and neutralizing “any attempt towards coalition, seduction, or privileged relationships with the therapist made by any member or subgroup of the family” (Selvini-Palazzoli et al., 1980, p. 7).

Neutrality becomes a synonym with the effort to avoid induction by the family system and with the ability to move freely in therapy. Perhaps, for Milan group, “neutrality” does what keeping the therapist in hierarchical superior position does for therapists like Haley and Minuchin, without the authoritarian implications. (Boscolo et al., 1987, p. 12)

Although circular questioning, hypothesizing, neutrality, and use of reflecting team may classify Milan group more toward de-centered and influential position, their initial interventions such as positive connotation, prescribing rituals to act differently in order to change “maps;” paradoxical prescriptions such as “sacrifice intervention;” and their goal to change “the family’s punctuation, meaning the way a situation or event was constructed” (Boscolo et al., 1987, p. 13) could put them more into an expert and hierarchical position or/and centered and influential position according to White. However, when Boscolo and Cecchin separated from other two members of original team, they tried to improve their model by changing the practice and concept of positive

connotation into the logical connotations, by including O-team and T-team in their reflective team practice, by shifting from family system to including larger systems, from more intervening to model of questioning, and so forth (Boscolo et al., 1987).

### **Strategic (Haley)**

Haley's strategic therapy also focuses on communicational patterns, sequences of behavior, and therapeutic strategies such as delivering directives to change behavior of family members; however, Haley also believed in importance of hierarchical structure in family (Haley, 1980). Haley (1980) in his treatment of eccentric young adults suggested that, "For the therapist, it is important to acknowledge that a problem young person is behaving irresponsibly and must be required to take responsibility for his actions" (p. 43). He also believed that "to correct the mad behavior, it is necessary to correct the hierarchy of the organization so that the eccentric behavior is not necessary or appropriate" (Haley, 1980, p. 44). "The task is not to resolve all family problems, only the organizational ones around the problem young person." (p. 46). Haley believed that "the therapist must be in charge" (p. 44) and take full responsibility for each case. Haley's centered position in therapeutic relationship is evident in his guidelines how to work with young eccentrics:

The focus should be on the problem person and his behavior...The focus is on what to do now. It is assumed that the hierarchy in the family is in confusion. Therefore if the therapist, with his expert status, crosses the generational line and sides with the young person against parents, he will make the problem worse. The therapist should side with parents against the problem young person, even if this seems to be depriving him or her of individual choices and rights, and even if he or she seems too old to be made that dependent. If the young person does not like

the situation, he or she can leave and become self-supporting. (Haley, 1980, pp. 44-45)

Furthermore, Haley (1980) stated that, “everyone should expect the problem person to become normal and not excuse failure. The experts should indicate to the family that there is nothing wrong with the child and that he or she should behave like others of the same age” (p. 45). Other directives Haley designed for different problems can be found in his books Directive Family Therapy, Ordeal Therapy, and Problem Solving Therapy. Haley (1976) explained that directives in therapy have three main purposes:

First, the main goal of the therapy is to get people to behave differently and so to have different subjective experiences. Directives are a way of making those changes happen. Second directives are used to intensify the relationship with the therapist. By telling people what to do, a therapist becomes involved in the action... When they come back for the next interview, the therapist is more important than if he had not given a directive. Third, directives are used to gather information. (p. 49)

Haley believed that successful therapy involves a therapist who knows how to solve the problem and that “if therapy is to end properly, it must begin properly- by negotiating a solvable problem and discovering the social situation that makes the problem necessary” (Haley, 1976, p. 9). Thus, Haley emphasized the importance of conducting the first interview properly. This includes therapist inviting everyone who lives with a family to come to their first meeting, and conducting a structured interview that consists of four stages:

1) a social stage in which the family is greeted and made comfortable; 2) a problem stage in which the inquiry is about the presenting problem; 3) an interaction stage in which the family members are asked to talk with each other; and 4) a goal-setting stage where the family is asked to specify just what changes they seek. (Haley, 1976, p. 15)

Based on the assumptions (what therapists think) and interventions (what therapists do) in Haley's strategic model of family therapy, these therapists' position in therapeutic relationship could be described as centered and influential, according to White's model that was defined in chapter I.

### **Trans-generational Family Therapy Models**

While strategic therapists focus on here-and-now and solving the presenting problem (they engineer a solution), therapists informed by transgenerational models, such as Bowen, Contextual, and Object Relation Family Therapy which are psychoanalytically based, focus on insight and education, and how internalized experience is transmitted between generations.

#### **Bowen Theory/ Family Systems Theory**

Bowen was influenced by natural systems theory and assumed that "the human is a product of evolution and that human behavior is significantly regulated by the same natural processes that regulate the behavior of all other living things" (Kerr & Bowen, 1988, p. 3). These processes are described as two counterbalancing life forces: individuality that "propels individual to follow its own directives, to be independent and distinct entity" (p. 64) and togetherness that "propels an organism to follow the directives of others, to be independent, connected, and indistinct entity" (p. 65).



Bowen observed that, “the emotional functioning of individual members was so interdependent that the family could be more accurately conceptualized as an emotional unit” (Kerr & Bowen, 1988, p. 7). Rather than seeing individuals as mentally ill, Bowen conceptualized individuals on a continuum on their emotional functioning ranging from highly dependent and reactive individuals (undifferentiated) to those more autonomous in their emotional functioning (differentiated) (Kerr & Bowen, 1988). According to Kerr and Bowen, in order to improve one’s level of differentiation and reduce anxiety, a person needs to develop more awareness of and control over his or her emotional reactivity. Kerr (1984) suggested that, “an objective ‘coach’ is required to assist people with their parental families. People are never calm enough and objective enough when they begin such a project” (p. 21) and they need monitoring when they get lost. Kerr (1984) explained family systems theory in the following way:

It is a method of managing emotionality and feelings that depends on increased awareness and a gradual learning process. This learning seems to occur at several levels. At the “upper” levels the learning involves the development of new ways of thinking about the emotional and feeling process within oneself and as it exists in the environment. At the deeper levels it seems to involve a kind of deprogramming of one’s emotional reactivity, at least to some extent. (p. 20)

He also suggested that, “the capacity to have one’s behavior less directed by one’s emotional reactivity and skewed notions about others, and less directed by the emotional reactivity and biases of others about you, permits closer and more sustained contact” (Kerr, 1984, p. 22).

Kerr and Bowen (1988) stressed that “the level of differentiation of the self and the level of chronic anxiety strongly influence the vulnerability of a relationship system as a whole to symptom development” (p. 163). “Symptom development, therefore, depends on the amount of stress and on the adaptiveness of the individual or family to stress” (p. 112). Bowen believed that anxiety is transmitted over multiple generations and over time; when chronic anxiety is building up, the symptoms develop in family. More specifically, “the lower the level of basic differentiation and/or the higher the level of chronic anxiety, the more prominent the symptom” (p. 120). In addition, “the lower the level of differentiation, the more likely the family, when stressed, will regress to selfish, aggressive, and avoidance behaviors; cohesiveness, altruism, and cooperativeness will break down.” (p. 93).

Bowen also believed that “a family does not change from very good functioning to very poor functioning in one generation” (p. 13) and that “much of man’s virtuous behavior, as well as his dysfunctional behavior, is rooted in his evolutionary heritage.” (p. 22). People tend to manage high levels of stress and anxiety by emotional cutoffs, triangulation, binding of anxiety (e.g., drugs, alcohol, overeating, overachieving), by increased need for togetherness, projection, denial, and so forth (Kerr & Bowen, 1988). However, according to family systems theory, people can learn how to reduce their level of chronic anxiety that will lead to higher levels of differentiation of self. This learning “depends on having courage to engage emotionally intense situations repeatedly and to tolerate the anxiety and internal emotional reactivity associated with that engagement” (Kerr & Bowen, 1988, pp. 120-121).

Bowen believed that the therapist can and should be objective observer of different processes in family system, as well as that it is important for the therapist not to be triangulated by family members, which requires high levels of differentiation of self from his or her family of origin. When anxiety in any relationship becomes too high, third person (e.g., the family member, friend, therapist) is triangulated so that tension is reduced in the relationship by spreading the anxiety (Kerr & Bowen, 1988). Bowen believed that “triangles are a product of the undifferentiation in the human process. The lower the level of differentiation in a family, the more important the role of triangulating for preserving emotional stability” (Kerr & Bowen, 1988, p. 139). The solution to this problem is possible “if the third person stays in contact with the twosome but remains detriangulated, equilibrium will be restored to the twosome and an anxiety driven progression to symptom development is unlikely” (p. 146). Kerr and Bowen (1988) said that, “detriangling is probably the most important technique in family systems therapy” (p. 150). They also pointed out that, “Nobody detriangles completely from any triangle, but the process of achieving even small increments of change can result in some increase in one’s basic level of differentiation.” (p. 157).

Therapists informed by this model of therapy construct a genogram with a family to not only gather information about the family members and their relationships, but also to reduce the overall anxiety in a family system (Burnett, 2013). As a result of helping cool the emotional reactivity down, family members can become more “thoughtful and less reactive with one another” (p. 69). “By establishing the therapist’s own differentiated presence with the family, the therapist is able to affect the overall level of reactivity in the family. By not allowing herself to become ‘triangled’ by them, she is

showing that she is able to absorb some of the family's relationship anxiety" (Burnett, 2013, p. 69). Bowenian therapists help clients "understand, challenge, and then better navigate the complexities of their complex family emotional system" (p. 70). The stance of a therapist in a therapeutic relationship with family members is described as objective and neutral, in which the therapist is coaching people how to better navigate their relationships in order to improve their differentiation of self and reduce their chronic and transmitted family anxiety (Baker, 2014). Given that the change is based on gaining new knowledge, insight, and understanding as well as implied preference for intellectual mode of functioning (responding rather than reacting), Bowenian therapists could be categorized as taking a centered and relatively non-influential position. They have ideas about what needs to happen for the family to function without symptoms, yet "the person of the therapist, rather than particular technique, is the primary therapeutic tool" (Becvar & Becvar, 2006, p. 151).

### **Contextual (Boszormenyi-Nagy)**

Contextual family therapy is shaped by both individual psychodynamic and family systems sources such as patterns of communication, power, and transactions in families over at least three generations (Goldenthal, 1993). What is unique about contextual family therapy is its emphasis on individual's needs for fairness in relationships and striving for balance between giving and receiving (Goldenthal). Thus, the role of contextual therapist is to help "people to think about fairness so that they can do something to increase the fairness of their relationships. Although insight into oneself and one's relationships can be very helpful, direct action that brings relationships closer to balance of fairness is always necessary" (Goldenthal, 1993, p. 7).

Contextual therapists believe that people can be understood by assessing four dimensions of their life and relationships. These include: 1) existential facts, such as biological, cultural, historical, racial, and personal facts (e.g., losing parent at early age, growing up with divorced parents, having parent who is abusing substances, and etc.) which is important in uncovering injustices, 2) psychology, that provides information about individual cognitive and emotional functioning (e.g., their anxiety, depression, personality disorder, ego defenses, coping styles), 3) family transactions and power, which includes patterns of communication, coalitions, triangulations, boundaries, family roles, and so forth, and 4) relational fairness or ethical dimension, that is central in this approach and focuses on individuals right to give and receive, their use of constructive and destructive entitlement, their invisible loyalties, and possibility of destructive parentification involved in family (Goldenthal, 1993). For example, “constructive entitlement leads a person to enter into responsible give-and-take relationships. Destructive entitlement leads person to act unilaterally in ways that may be destructive to others” (Goldenthal, 1993, p. 17). Destructive entitlement is believed to result from inadequate parenting, very early loss, any type of abuse, being victimized by oppression, and so forth. According to this model, acknowledging past or present injustices in person’s life is important because it reduces a person’s need to rely on destructive entitlement or parentification (Goldenthal, 1993).

In therapeutic relationship with their clients, contextual therapists are active and raise issues of relational balances. They advocate for all family members regardless of their presence in therapy. Using what contextual therapists call multidirected partiality, a therapist is not taking a neutral stance, but rather, is required “to work hard to see a

situation from the perspectives of each individual who are likely to be affected by the course of therapy” (Goldenthal, 1993, p. 19). In other words, “in contextual work, partiality can be more specifically defined as a therapist’s commitment to help everyone in his client’s relational world who is likely to be affected by therapeutic intervention” (Boszormenyi-Nagy & Krasner, 1986, p. 302). Goldenthal (1993) explained that, “a multidirected stance permits and even encourages taking sides, but requires the therapist to try to take all sides equally” (Goldenthal, 1993, p. 48). Timing, inclusiveness, empathy, crediting, and expectation that people care and do for one another are all aspects of multidirected partiality. “Multidirected partiality can eventually lead to a redistribution of intermember burdens and benefits, to a shift in transactions and roles, and, usually, to more responsive parental and marital care” (Boszormenyi-Nagy & Krasner, 1986, p. 304).

In order to develop a trusting therapist-client relationship and achieve multidirected partiality as therapeutic attitude, Boszormenyi-Nagy and Krasner suggested that, “a therapists needs personal freedom, conviction, courage, knowledge and skills, a capacity for empathy, and ability to claim his or her own private existence” (p. 400).

A therapist’s role is one of a concerned caretaker... he is needed authority to whom to talk, a wished for anchor point for security and stability, and a reservoir of trust...A therapist offers responsibility, skill, care, and the willingness to open up controversial, painful, shameful, and trying issues, earning trustability in the process...Part of a therapist’s usefulness has to do with nonspecific supportive help. (Boszormenyi-Nagy & Krasner, 1986, pp. 395- 396)

In addition to multidirected partiality, contextual therapists use other interventions to address fairness issues in family relationships such as crediting, helping people acknowledge each other's giving, giving room, lending weight, and exoneration (Goldenthal, 1993). Contextual therapists could be categorized as taking a relatively decentered and influential position, according to White's matrix.

### **Object Relations Family Therapy**

Object relations family therapy was greatly influenced by Freud's psychoanalysis and object relation theory (Scharff & Scharff, 1987). This form of therapy "derives from psychoanalytic principles of listening, responding to unconscious material, interpreting, developing insight, and working in the transference and countertransference toward understanding and growth (Scharff & Scharff, 1987, p. 3). In addition to focusing on exploring intrapsychic of each individual in family in form of transference, object relations family therapists view family as an interrelated system and they explore contextual transference and countertransference in family system. These therapists "think of transference as the living history of ways of relating, influenced by the vicissitudes of infantile dependence and by primitive emotions of a sexual and aggressive nature that arise in pursuit of attachment" (Scharff & Scharff, 1987, p. 203). Thus, each individual brings his or her internalized object relations patterns from previous relationships to current relationship. The therapist sees problems in current relationship as a result of psychic development in early parent-child relationship and internalized object relations.

The relationship between the therapist and the client(s) is at the center of the object relations therapists' clinical work (Scharff & Scharff, 1987). Object relations

therapists “provide a holding function that allows the family to move toward truly understanding each other at the core” and provide interpretation that helps family members to “modify their internal object relations system” (Scharff & Scharff, 1987, p. 62). The goal of object relations approach is to:

expand family’s capacity to perform the holding functions for its members and their capacities to offer holding of each other. Thus, the pairing of the process of providing understanding of their overall situation with the process of helping each of them to have more understanding and compassion for each other forms the essential of the task, which is analogous to, and derives from, the mother’s paired tasks of creating the mothering environment while communicating with the baby’s internal world. (Scharff & Scharff, 1987, p. 62)

Scharff and Scharff (1987) described the therapeutic relationships in the following way:

The object relations approach, like the process of raising children, is a matter of being with our patients. Our attempts to share our understanding are more than language. They are our ways of both holding the whole family and getting in touch with the family’s core. Our interpretations are intended to let the family see what we are doing to understand them and to bear their anxieties. At the same time, the interpretations offer the family and its members the opportunity to respond to us, to look us back in the eye, and to set us straight. They need to be able to do this with us if they are to manage to do it with each other. (pp. 62-63)

It seems that the therapeutic relationship provides opportunity for clients to learn a better way of relating by becoming aware of their unconscious object relations that are



troubling their current family relationships. For that learning and new understanding, the therapist creates a relational context in which:

the patient is forced to move toward the analyst for an attachment. Because analyst remains at more or less steady distance, the patient is pulled forward, out of retreat. This could be thought of as manipulation, except that it seems to be necessary condition for getting the internal world out into the open...When this happens, it is a matter of reliving old events from various periods of development...in present, where appropriateness and inappropriateness of the patient's responses can be observed not only by the analyst but, more important, by the patient, who can then see which events in current life tend to trigger old responses-responses that treat the current person (the analyst) as though he or she actually were the internal objects. (Scharff & Scharff, 1987, p. 204)

Thus, the therapist is an observer who fosters insight and understanding by interpreting unconscious material and analyzes a defensive system of the family. Object relations family therapists also believe that “transference and resistance can be considered to be interpersonal phenomena, deriving from internalized object relationships recreated in the therapeutic relationship” (Scharff & Scharff, 1987, p. 206). When making interpretations, therapists are “attending to the links between what is said and not said and to non-verbal communications” (p. 8). Even though the interpretation is considered essential in this approach, object relations therapists believe that “interpreting that fails to lead to insight, or sitting back when interpretation is needed, certainly will not help families.” (p. 8). In addition to interpretations about current situation, object relations therapists use interventions such as comments about organizing session (e.g., calming

chaos), comments about transference, and giving support and advices (Scharff & Scharff, 1987). It appears that object relations family therapists take a centered and relatively influential position, according to White's matrix described in chapter I.

### **Structural Family Therapy**

Structural family therapists facilitate the transformation of the family structure by first joining the family system as a leader, then by evaluating underlying family structure, and finally by creating "circumstances that will allow the transformation of this structure" (Minuchin, 1974, p. 111). What Minuchin meant by leadership is that the therapist is responsible for what happens in therapy and whether family members reach their growth and healing (Minuchin, 1974). Structural family therapists could be described as taking a centered and influential position in therapeutic relationship because "The therapist must assess the family and develop therapeutic goals based on that assessment. And he must intervene in ways that facilitate the transformation of the family system in the direction of those goals" (Minuchin, 1974, p. 111). Moreover, Minuchin (1974) designed several interventions or operations for restructuring that therapists may use in assisting the families that consult them. These include but are not limited to: "actualizing family transactional patterns, marking boundaries, escalating stress, assigning tasks, utilizing symptoms, manipulating mood, and supporting, educating, or guiding" (p. 140).

The relationship between the therapist and the family is of great importance in structural family therapy. Minuchin (1974) pointed out that, "Unless the therapist can join the family and establish a therapeutic system, restructuring cannot occur, and any attempt to achieve the therapeutic goals will fail" (p. 123). Minuchin further explained that, "When the therapist joins the family, he has two main tasks. He must accommodate

to the family, but he also must maintain himself in a position of leadership within the therapeutic unit.” (p. 139). Minuchin’s leadership and expert position can be evident from the following excerpt:

For instance, in a situation in which a fourteen-year-old child is having difficulties in school and his parents are in conflict about how to deal with this, I might make three interventions. Joining the husband, I would say, “A coalition between your wife and your son is making you helpless.” Joining the wife, I would say, “The inability of your husband and son to resolve conflicts is overburdening you, making you responsible for taking care of both of them.” Joining the son, I would say, “Your father and mother are arguing about your difficulties in school without giving you any chance to participate. They are keeping you younger than you are.” I then ask them to enact a change in the session. (Minuchin, 1974, p. 121)

It appears that Minuchin tries to join with each family member by providing his expert knowledge in form of multiple interpretations. Minuchin (1974) also described his stance in the relationship with his clients in the following way:

I have learned to disengage myself and to direct the family members to play out their own drama while I am observing. I am spontaneous with interventions, having learned to trust my responses to families. But I continuously observe the order and rhythm of family communications, making conscious decisions about when to talk to whom.

As a therapist, I tend to act like a distant relative. I like to tell anecdotes about my own experiences and thinking, and to include things I have read or heard that are relevant to the particular family. I try to assimilate the family’s language and to

build metaphors using the family's language and myths. These methods telescope time, investing an encounter between strangers with the affect of an encounter between old acquaintances. They are accommodation techniques, which are vital to the process of joining. (p. 122)

In order to join with, and subsequently intervene in a family, the therapist needs to accommodate or adapt to the family (Minuchin, 1974). In other words,

To join a family system, the therapist must accept the family's organization and style and blend with them. He must experience the family's transactional patterns and the strength of those patterns...He must accommodate to the family, and intervene in a manner that the particular family can accept. (pp. 123-125).

Minuchin (1974) believed that the therapist could change the family and "has the skills to do so. But his goals, his tactics, and his stratagems are all dependent on the process of joining" (p. 125). He proposed several accommodation techniques that may help not only with joining but also may serve as a restructuring operation. These techniques include: a) maintenance (e.g., supporting certain subsystems, accepting labeling of identified patient temporarily, confirming individuals); b) tracking (e.g., asking clarifying questions, giving approving comments, asking them to continue conversation); and c) mimesis (e.g., adopting family's pace in communication, mimicking behavior, sharing common personal experiences with clients). Given that structural therapists position themselves as leaders with expert knowledge, who have normative ideas about what constitutes functional/dysfunctional families, and are very active in intervening through restructuring operations in order "to increase the flexibility of (these) underlying structures" (Minuchin & Nichols, 1993, p. 40), they could be described as taking a

centered and influential position in their relationship with clients, according to White's matrix.

### **Virginia Satir**

Satir's model of family therapy is focused on teaching families congruent communication and achieving wholeness as a person (Satir, 1975). Satir (1975) believed that it is the therapist's responsibility whether family grows or not; therefore, she considered "the therapist the leader of the treatment situation" (p. 38) with "primary responsibility of change agent" (p. 37). Problems are seen as a result of low self-esteem, which leads to dysfunctional communication (Satir, 1967). According to Satir, in times of stress, individuals tend to handle communication using five different modes of communication: 1) placating, 2) blaming, 3) super-reasonable, 4) irrelevant, and 5) congruent. The goal of therapy is to help clients get in touch with their experience and to become congruent in what they feel and communicate (Satir, 1975).

Making it possible for people again to see freely and comment openly on what they see, to be able to hear freely and comment on what they hear, and to be able to touch freely and be able to comment openly on that experience – these comprise the restorative task. (Satir, 1975, p. 82)

Satir (1975) also believed that "pain comes from the feeling of being alienated, of feeling not loved, or feeling doubtful about your lovability" (p. 79) and that "illness comes from ...the person's inability to use all his parts" (p. 83). Satir said, "If you were to see me interview families, you would find that I put more attention on looking, hearing, and touching, than I do on the talk about the problem" (pp. 82-83). She would ask families to role-play different communication modes and then get in touch with how they felt in their

roles and how connected they felt with the rest of the family (Satir, 1975). In this sculpting technique or exercise, family members are able to achieve new awareness and interpretations by experiencing themselves and their feelings in a safe environment. In addition to sculpting, Satir (1975) used metaphors, games, and humor as techniques to intervene. Satir (1975) believed that “to help a human being change and grow, the reconstruction of that person takes place 1) in the area of communication, 2) in the area of belief about being able to grow, and 3) in the area of restoring the use of senses.” (p. 83). In her earlier writing, Satir (1967) stressed that maturity is what makes a person functional. A mature or functional person will:

- a. manifest himself clearly to others.
- b. be in touch with signals from his internal self, thus letting himself know openly what he thinks and feels.
- c. be able to see and hear what is outside himself as differentiated from himself and as different from anything else.
- d. behave toward another person as someone separate from himself and unique.
- e. treat the presence of different-ness as an opportunity to learn and explore rather than as threat or a signal for conflict.
- f. deal with persons and situations in their context, in terms of “how it is” rather than how he wishes it were or expects it to be.
- g. accepts responsibility for what he feels, thinks, hears and sees, rather than denying it or attributing it to others.
- h. have techniques for openly negotiating the giving, receiving and checking the meaning between himself and others. (Satir, 1967, p. 92)

Satir (1967) saw the role of the therapist as a “resource person” who has “a special advantage in being able to study the patient’s family situation as an experienced observer, while remaining outside it” and who is a “model of communication” (p. 97). “The therapist will not only exemplify what he means by clear communication, but he will teach his patients how to achieve it” (Satir, 1967, p. 100). Satir (1967) recommended that “the family therapist not only intervene in family therapy sessions but that he also structure at least the first two sessions by taking a family life chronology” (p. 112). Based on predetermined assumptions in this model about what constitutes healthy and unhealthy individual and what causes problems as well as what leads to being more congruent and healthy, therapists using this approach could be characterized as taking a centered and influential position in their relationship with people who consult them, according to White. This model is also an example of first order cybernetics given that a therapist is outside of family system, acting as an expert observer, who diagnoses communicational patterns and then provides input through teaching of more congruent communication.

### **Carl Whitaker**

Whitaker’s symbolic-experiential therapy emphasizes emotional experiences of family members, being personal and honest, and exposing personal pain as essential requirement for change (Whitaker & Bumberry, 1988). Whitaker and Bumberry stated:

We organize our lives around our own limited, internal representational systems.

The richer and more diverse this world, the more freedom and creativity we have.

If we can aid in expansion of the symbolic world of the families we see, they can live richer lives. (p. 75)

They added that symbolic-experiential therapy is focused on “helping people become more comfortable in their impulse living, to be less frightened by it, and to integrate it more fully into their concrete living” (Whitaker & Bumbery, 1988, p. 79). In other words, “Symbolic therapy is an effort to deal with the representation system underneath what’s actually being said. It involves picking up on the symbolic bits and fragments that you detect or sense” (Whitaker & Bumbery, 1988, p. 78). Whitaker used different strategies to help people become more emotionally engaged with each other and to achieve growth, which he described as: “an increased tolerance for the absurdity of life” and “achieving the state of balance between belonging and individuating” (Whitaker & Bumbery, 1988, p. 86). His strategies include, but are not limited to, sharing his association, reframing, relabeling interactions, introducing confusion so that clients’ explanation of the symptom is expanded, offering ridiculous solutions, pressing them in opposite direction, overstating the issues, blaming someone for being dishonest to provoke response, and so forth (Whitaker & Bumbery, 1988). Whitaker believed that, “True emotional growth occurs only as a result of experience” (p. 85) and that, “Insights and understanding happen as a result of experience, not as a precursor to it” (p. 86).

Carl Whitaker saw “the whole family as the patient” (Whitaker & Bumbery, 1988, p. 59) since he believed that “all of life and all of pathology is interpersonal” (p. 36). He also believed that people “seek simultaneously deeper levels of belonging and individuating” (p. 10); that, “they have within themselves the capacity to struggle and grow” (p. 20); and that, “they need to accept the fact that they remain responsible for their own living” (p. 6). At the beginning of the treatment, Whitaker explains his



expectations and also asks family members “to be personal right of the bat” (Whitaker & Bumberry, 1988, p. 12).

The relationship with clients is clearly described in this model of therapy through what Whitaker calls, the Battle for Structure and the Battle for Initiative. Whitaker believed that the therapist is the one who needs to win the Battle for Structure. The therapist needs to decide “who attends the sessions, who is asked to talk first, what the therapist accepts as a definition of the problem, etc.” (p. 56). Furthermore, Whitaker and Bumberry (1988) explained:

The Battle for structure is the period of initial political jousting with the family...As they begin to hear and absorb the conditions and limitations I am presenting, their automatic response is to begin to piece together their own “we position”... In setting these conditions, I want to engage the family in an interactive process that leads to an experiential exchange. In order for the process of therapy to be impactful rather than merely educational or social, it must consist of real experiences, not just head trips. (p. 56)

On the other hand, the Battle for Initiative means “to get them to take responsibility for what happens in therapy” (p. 65). Whitaker and Bumberry (1988) pointed out that “you need to disrupt the fantasy that you’ll make it all better...It’s often a period accented by tension and anxious silences” (p. 66) between the therapist and the family members. In contrast to Bowen, Whitaker did not try to reduce clients’ anxiety. Whitaker said that, “I don’t want to relieve their anxiety. I want their anxiety to be the power that makes things move.” (p. 11). To win the Battle for Initiative, the clients, rather than their therapist, need to decide whether they will come back for another session. Whitaker believed that,

“Additionally, they need to accept the fact that they remain responsible for their own living. Attempting to relinquish control or responsibility to me will do nothing to enhance their living.” (p. 6)

The position of the therapist in symbolic-experiential therapy is described as being “responsive to the family without being responsible for them” (p. 43). More specifically, it is a position of “symbolic parent” (45) who can be “both caring and tough” (p. 38). According to Whitaker and Bumberry (1988), “While the capacity to be nurturing is central, the capacity to be tough is equally essential” (p. 39). Whitaker also described taking an expert role in relationship with a family, as someone who is outside of the family system, impacting their functioning, as in first order cybernetics.

In beginning, my effort is to establish a metaposition in relationship to the family.

I want them to understand more of what they can expect from me and what I expect from them. This is not designed as a relationship between peers. I want it understood that in my role as a therapist I’m a member of an older generation.

The metaphor of a coach of baseball team is a good way of describing what the relationship will be. As the coach, I’m really not interested in playing on the team, only in helping them play more effectively. (Whitaker & Bumberry, 1988, p. 58)

A therapeutic alliance is also described as successful completion of the Battle for Structure and the Battle for Initiative (Whitaker & Bumberry, 1988).

I’m free to be responsive to them rather than responsible for them. Typically, the family is more accepting of my moves to get more personal, as well as my decisions to separate or move out. I can individuate and belong without too much distortion...Our increasing comfort with individuating and joining reflects real

growth and marks a more adaptive, healthy system. It's during this period that the family begins to make some changes. (Whitaker & Bumberry, 1988, p. 67)

Even though Whitaker is not interested in taking responsibility for his clients, he takes an expert role as a symbolic parent who is both tough and caring and who believes that family members need courage to learn how to live with absurdity of life and to increase their emotional growth. According to White's matrix described in chapter I, symbolic-experiential therapists could be categorized as taking a relatively centered and influential position in relationship with people who consult them.

### **Emotionally Focused Couple Therapy (EFT)**

Johnson and Greenberg's Emotionally Focused Couple therapy (EFT) places great emphasis on reorganizing emotional experiences and establishing secure bonds between partners. This model of therapy is an integration of experiential and systemic approaches and Bowlby's attachment theory (Johnson, 2008). Johnson reports that her, basic agenda in therapy is to help people step out of negative cycles that increase their attachment insecurity all the time, bring up all these difficult emotions, and help them step into a place where they can dance together in a more accessible and responsive manner. (Young, 2008, p. 226)

In emotionally focused therapy "the purpose is to generate a corrective emotional experience and interactional experience of self in relation to other" (Johnson, 2004, p. 107). The therapist sees marital distress as a result of insecure attachments and focuses on what is blocking the emotional accessibility and responsiveness in partners (Young, 2008). After identifying negative interactional cycle and after accessing unacknowledged attachment oriented emotions, the therapist reframes the problems in terms of cycle and

of attachment needs and fears, and then helps them “create new cycles of positive bonding, where they can talk about their emotions in a whole different way and connect in a whole different way” (Young, 2008, p. 267). Johnson (2004) described the role of the therapist in the following way:

The therapist in EFT acts as a guide, a process consultant, to the reprocessing and reorganization of emotional experience in relation to the partner, and to the reorganization of interactions in such a way as to promote emotional engagement and secure bonding. (p. 106)

The creation and maintenance of a therapeutic alliance is the first task in emotionally focused therapy (Johnson, 2004). Johnson (2004) believes that a positive therapeutic alliance is necessary for a positive outcome, but it is not sufficient in itself for change. “In EFT, this alliance is characterized by the therapist’s being able to be with each partner as that partner encounters his or her emotional responses and enacts his or her position in the relationship” (Johnson, 2004, p. 58). The therapeutic alliance was also found to be a significant predictor for the successful outcome of emotionally focused couple therapy in a study by Johnson and Talitman (1997).

The position of the EFT therapist in the relationship with clients is characterized by: empathic attunement, acceptance, genuineness, continuous active monitoring of alliance, and joining the system by validating experiences of each partner and “helping the couple take a metaperspective on their interactions” (Johnson, 2004, p. 63). The EFT therapist focuses on non-verbal messages and is “willing to explain what he or she is doing in terms of intervention and how this will help the therapy process” (Johnson, 2004, p. 62). Johnson (2008) also believes that, “Timing and delivery of the

interventions are as important as the interventions themselves” (p. 117). “From the beginning, the EFT therapist validates each partner’s construction of his or her emotional experience and places this experience in the context of the negative interactional cycle” (Johnson, 2008, p. 119). “Once the alliance is established, there are two main basic therapeutic tasks in EFT: 1) the exploration and reformulation of emotional experience, and 2) the restructuring of interactions” (Johnson, 2008, p. 120). It seems that EFT therapists are taking an expert role in accessing the insecure attachments, in reframing the problems as negative interactional cycle, and in intervening to correct and reorganize emotional experiences and to create a secure bond between partners. Therefore, they could be categorized as taking a centered and influential position in the relationship with their clients, according to White’s matrix.

### **Feminist Family Therapy**

In the late 1970s and in 1980s a group of female family therapists: Walter, Carter, Papp, and Silverstein explored the issues and experiences of women in patriarchal culture, examined the role of gender in family therapy models and interventions, and raised awareness on gender inequality and gender biases in mental health treatment process that tended to pathologize women (Walters, Carter, Papp, & Silverstein, 1988). Walters et al. (1988) believed that, “No context could be more pertinent to the understanding of all family systems than that of gender. There is no “neutral” context within which human systems exists” (p. 3). Therefore, a gender neutrality does not exist, according to Walters et al., and “neutrality” means leaving the prevailing patriarchal assumptions implicit, unchallenged, and in place” (p. 18).

On the other hand, a feminist framework is concerned with the cultural gender based pre-determined rules and roles that organize male-female interactions. Walters et al. (1988) defined feminism in a following way:

Feminism seeks to include the experience of women in all formulations of human experience, and to eliminate the dominance of male assumptions. Feminism does not blame individual men for the patriarchal social system that exists, but seeks to understand and change the socialization process that keeps men and women thinking and acting within a sexist, male-dominated framework. (p. 17)

Walters et al. (1988) noticed that women are disadvantaged in our society and they believed that not acknowledging it in therapy would reproduce the dominant sexist discourse, which privileges male dominance. In addition, “all interventions need to take gender into account by recognizing the different socialization processes of women and men” (Walters et al., 1988, p. 17). Walters et al said that, “We need to recognize that each gender hears a different meaning in the same clinical intervention and accordingly feels either blamed or supported by an identical therapeutic stance” (Walters et al., 1988, p. 17).

Even though Walter, Papp, Carter, and Silverstein practiced using the different models of family therapy, they examined, challenged, and stopped using systemic interventions that are used to disadvantage women. For example, they challenged the complementary roles that are based on male hierarchy; instead, they preferred egalitarian approach to power or symmetrical relationships in which both partners are participating in the instrumental and expressive tasks at home and at work. They also challenged the idea that “dependency” for women and “autonomy” for men are intrinsic or natural traits

rather than assigned to them by a patriarchal society and developed through socialization process. Thus, feminist family therapists challenged the concepts such as reciprocity, fusion and distance, complementarity, hierarchy, boundaries, triangles, and function of the symptom, which are used to describe dysfunction and assign traditional roles as the basis for healthy family functioning (Walters et al., 1988).

Feminist family therapists stress egalitarian relationships between the therapist and the clients (Hare-Mustin, 1978). However, they “can intervene in many ways to change the oppressive consequences of stereotyped roles and expectation in the family” (Hare-Mustin, 1978, p. 8) which tends to put them in an influential position. Feminist family therapists are also aware that “therapy is a political act and cannot be separated from the social issues in which the family is embedded” (Walters et al., 1988, p. 29). Feminist therapists not only raised awareness on gender inequality in family therapy, but also raised the issues of social injustice by exploring ethnicity and race; the relationship between the heterosexual community and lesbian couples (Silverstein, 2003); the male-gender socialization process and specific cultural requirements for achieving “manhood” and what it means to be a “real man” (e.g., self-reliant, invulnerable, in control) (MohdZain, 2001). Strategies used in feminist approach differ based on a theoretical orientation of the therapist; however, the feminist therapists try to address gender and power and they help clients identify oppressive social norms by deconstructing their ways of thinking (Seem, 2001). They also “use self-disclosure as a way to reduce the artificial hierarchical boundaries that exist between therapists and clients” (Seem, 2001, p. 36). Therefore, feminist family therapists could be perceived as taking a decentered and influential position. However, they could also be seen as taking a centered position if

their agendas of justice and equality are not consistent with clients' wishes for their relationship.

### **Postmodern Approaches**

Postmodern movement in family therapy occurred as a result of dissatisfaction with and reaction to a positivism and empiricism or a modern worldview, which emphasizes objectivity, discovery of the Truth, totalizing discourses, and language as reflecting or representing reality rather than creating reality. The role of the therapist is that of a social engineer who possesses technologies and “scientific” knowledge to objectively assess, diagnose, and repair individuals, relationships, and families. Thus, the modern worldview places the therapists in an expert, authoritative, and highly hierarchical position in a relationship with their clients, since it is assumed that they can objectively observe, discover facts, make predictions based on their theories, and cure people as machines from their deficiencies and disorders. Michael White called this position of the therapist “centered.”

Postmodernism rejected these ideas and opened the door for exploring multiple realities, for questioning and deconstructing dominant cultural discourses, and for placing the therapist in more of a collaborative relationship with clients by taking a non-expert and non-knowing stance in regard to how clients should be, what they mean, and how they should lead their lives. Rosenau (1992) explained postmodernism in social sciences as a cultural critique and movement in “re-conceptualization of how we experience and explain the world around us” (p. 4).

Post-modern social science focuses on alternative discourses and meaning rather than on goals, choices, behavior, attitudes, and personality...Post-modernists,



defining everything as a text, seek to “locate” meaning rather than to “discover” it. They avoid judgment, and the most sophisticated among them never “advocate” or “reject,” but speak rather of being “concerned with” a topic or “interested in” something... They offer indeterminacy rather than determinism, diversity rather than unity, difference rather than synthesis, complexity rather than simplifications. They look to the unique rather than to the general, to intertextual relations rather than causality, and to the unrepeatable rather than the re-occurring, the habitual, or the routine. (Rosenau, 1992, p. 8)

The family therapies influenced by postmodernism and social constructivism include narrative therapy, collaborative language system therapy, and solution-focused brief therapy.

### **Collaborative Language Systems**

Anderson and Goolishian’s collaborative language systems model of family therapy focuses on a co-creation of new and different meanings in a dialogue between the therapist and the client(s) in which the client’s problems are dissolved through language rather than fixed by finding new solutions (Anderson & Goolishian, 1988). “In this sense, problems exist in language and problems are unique to the narrative context from which they derive their meaning” (Anderson & Goolishian, 1992, p. 28). Anderson and Goolishian’s position is based on assumptions that “human systems are language-generating systems,” that “therapy is a linguistic event that takes place in what we call a therapeutic conversation,” and that “the therapeutic system is a problem-organizing, problem dis-solving system” (Anderson & Goolishian, 1992, p. 27). “Problems are in the intersubjective minds of all who are in active communicative exchange and, as such, are

themselves always changing” (Goolishian & Winderman, 1988, p. 136). “Change is the evolution of new meaning through dialogue” (Anderson & Goolishian, 1988, p. 372). Thus, the goal of collaborative language systems therapy is not to fix systemic structures or psychic defects as in other models of psychotherapy, but rather to engage in “the continuation of the therapeutic conversation such that the co-created narrative which arises no longer includes that which was experienced as a problem or alarmed objection” (Goolishian & Winderman, 1988, p. 137). In the other words, the “problems” dis-solve as the conversation about the defined problems change. Anderson and Goolishian (1988) believe that, “We live with each other in a world of conversational narrative, and we understand ourselves and each other through changing stories and self-descriptions” (p. 380). They also believe that, “meaning and understanding in dialogue and conversation are always an interpretive activity and always in flux and change...All meaning, understanding, and interpretation is inherently negotiable and tentative” (Anderson & Goolishian, 1988, p. 381).

The role of the therapist is that of a conversational artist – an architect of the dialogical process – whose expertise is in the area of creating a space for a facilitating a dialogical conversation. The therapist is a participant-observer and a participant-facilitator of the therapeutic conversation. (Anderson & Goolishian, 1992, p. 27)

The therapist in this model is viewed not as someone who operates upon the family system, as in first order cybernetics, but as someone who is a part of the linguistic meaning system and as someone who provides context for co-development and co-creation of different narratives, meanings, and understandings. In addition,

The therapist exercises this therapeutic art through the use of conversational or therapeutic questions. The therapeutic question is the primary instrument to facilitate the development of conversational space and the dialogical process. To accomplish this the therapist exercises an expertise in asking questions from a position of ‘not-knowing’ rather than asking questions that are informed by method and that demand specific answers. (Anderson and Goolishian, 1992, pp. 27-28)

Anderson and Goolishian (1992) explained that, “Therapeutic questions always steam from a need to know more about what has just been said. Thus, the therapist is always being informed by the client’s stories and is always learning new language and new narrative.” (p. 32). “The therapist is “in there” as a learner, cooperating with, attempting to understand, and working within the client’s meaning system” (Anderson & Goolishian, 1988, p. 384). In addition, “The therapist does not control the interview by influencing the conversation toward a particular direction in the sense of content or outcome, nor is the therapist responsible for the direction of change.” (Anderson & Goolishian, 1988, p. 385). According to Anderson and Goolishian, the therapist is only responsible for opening a space for dialogical conversation and taking a stance of multipartiality, which entails “taking all sides and working within all views simultaneously” (p. 385). In addition, through collaborative dialogue in which the therapist takes non-hierarchical position, the therapist is also subject to change not only client. Anderson and Goolishian (1988) suggested that,

We, as therapists, are always taking positions. As therapists we are never void of values and always operate on the basis of these views. These prejudices, however,

are not imposed on clients. Rather, therapist and client in dialogue with one another are always acting on and reflecting their ideologies, their values, and their views. To be in dialogue is to attempt to understand others and to involve oneself in the coevolution of understanding and meaning. (p. 385)

Genuine and abundant curiosity as well as being informed by client characterizes the “not-knowing” position, general attitude, or stance of the therapist in this model.

The therapist does not ‘know’ priority, the intent of any action, but rather must rely on the explanation made by the client. By learning, by curiosity, and by taking the client’s story seriously, the therapist joins with the client in a mutual exploration of the client’s understanding and experience. (Anderson & Goolishian, 1992, pp. 29-30)

Anderson and Goolishian (1992) explained that “not-knowing” position does not mean that the therapists are free from their judgment; rather, it means that “they must listen in such a way that their pre-experience does not close them to the full meaning of the client’s descriptions of their experience” (p. 30). In addition, by taking a not-knowing stance,

the therapist does not dominate the client with expert psychological knowledge so much as he or she is led by, and learns from, the expertise of the client. The therapist’s task, therefore, is not to analyze but to attempt to understand, to understand from the changing perspective of the client’s life experience.

(Anderson & Goolishian, 1992, p. 33)

By taking a not-knowing stance, the therapist is also able to open a conversational space for co-creation of new meaning and narrative. According to White’s matrix (described in

chapter I), the position of the therapist in collaborative language systems therapy could be categorized as a decentered and non-influential.

### **Solution-Focused Brief Therapy**

Solution-focused brief therapy (SFBT) is a goal-oriented, future-focused, and brief model of therapy that was developed inductively by Steve de Shazer, Insoo Kim Berg and their colleagues in the early 1980s (de Shazer, Dolan, Korman, Trepper, McCollum, & Berg, 2007). In this model, the therapist helps clients build solutions; encourages clients to do more of what is already working; helps them identify and take small steps toward change; asks questions (i.e., miracle question) to set clear, concrete, small, specific, and manageable goals; helps clients look for exceptions to the problems and previous solutions; asks scaling questions to scale the problem and the goal and to assess their progress; compliments their strengths and progress; and gives experiments and homework assignments (de Shazer et al., 2007). SFBT therapists may also ask coping questions, ask about pre-session change, and they usually take a break during the session before delivering a homework assignment. If there is a team behind the mirror, the therapist asks them during the break to make a list of compliments for all family members and to design intervention for them based on their strengths, previous solutions, and exceptions (de Shazer et al., 2007).

SFBT therapists believe that “problems are best solved by focusing on what is already working, and how a clients would like his or her life to be, rather than focusing on the past and the origin of the problems (de Shazer et al., 2007, p. 5). By focusing on exceptions and previous solutions the therapist moves the client from problem-talk to a “solution-talk mode” (de Shazer et al., 2007, p. 6).

The SFBT therapist spends most of the session listening attentively for signs of previous solutions, exceptions, and goals. When these come out, the therapist punctuates them with enthusiasm and support. The therapist then works to keep the solution-talk in the forefront. (de Shazer et al., 2007, p. 9)

Given that the goal of SFBT is to build solutions, the therapist prefers solution talk versus problem talk. In addition, the SFBT therapist is

helping the client maintain desired changes. This is accomplished by learning exactly how the client behaved or responded differently during periods of improvement. As a result of identifying what worked, the client is able to repeat the success and the solution further evolves. (de Shazer et al., 2007, p. 2)

The position of the therapist can be understood not only based on what the therapists do in the relationship with the clients but also by examining the underlying assumptions of the model. According to de Shazer et al. (2007) the major tenets of SFBT include:

- 1) If it isn't broken, don't fix it. 2) If it works, do more of it. 3) If it's not working, do something different, 4) Small steps can lead to big changes. 5) The solution is not necessarily directly related to the problem. 6) The language of solution development is different from that needed to describe the problem. 7) No problems happen all the time; there are always exceptions that can be utilized. 8) The future is both created and negotiable. (pp. 1-3)

Steve de Shazer et al. (2007) described a stance of solution-focused brief therapists as “positive, collegial, and solution-focused” (p. 4).

The overall attitude is positive, respectful, and hopeful. There is a general assumption that people have within them strong resiliencies, and can utilize these

to make changes. Further, there is a core belief that most people have the strength, wisdom, and experience to effect change. (de Shazer et al., 2007, p. 4)

Berg and Dolan (2001) explained that the therapeutic relationship in SFBT is more equalitarian and democratic than authoritarian. The therapist's position is also defined as "leading from one step behind." Berg and Dolan described this position in following way:

SFBT therapists do not shy away from leading; however, rather than pushing, cajoling, or pulling their clients in certain directions, they lead from behind. From this position, the therapist gently "taps the client on the shoulder" and asks whether she noticed the beautiful sunset in the sky or that tiny wild flower swaying in the breeze. These "taps on the shoulders" are the questions that the therapist asks in order to stimulate a fresh look at the same old picture. (p. 3)

In addition, "leading from behind indicates a gentle, respectful approach that recognizes and accepts the client's choice" (Berg & Dolan, 2001, p. 99).

Deciding when to lead and when to lag behind requires sensitivity and willingness to allow clients to make informed choices, trusting that they know what is ultimately best for them. Leading from behind begins with listening to what the client says is important, even when it seems to go against common sense and conventional wisdom. (Berg & Dolan, 2001, p. 99)

In contrast to psychodynamic schools of thought, the SFBT views resistance as a result of either a) client's "natural protective mechanism, or realistic desire to be cautious and go slow or b) a therapist's error, i.e., an intervention that does not fit the client's situation" (de Shazer et al., 2007, p. 4). de Shazer (1985) believed that clients want to change, and

figured out the way to promote cooperation rather than to create resistance. In order to do that the therapist needs to approach the client in the following way:

First we connect the present to the future (ignoring the past), then we compliment the clients on what they are already doing that is useful and/or good for them, and then – once they know we are on their side- we can make a suggestion for something new that they might do which is, or at least might be, good for them. (de Shazer, 1985, p. 15)

Even though SFBT recognizes that the clients are experts on their lives and are allowed to develop their own solutions, they also take expert role in leading and making suggestions through homework assignments and judgments in form of giving clients compliments. They also make assessments by asking scaling questions and they are not particularly interested in client's problems, instead, they prefer to lead solution-talks believing that problems are not necessarily connected to solutions. SFBT therapists also advise and encourage clients to do more of what is working. According to White's matrix (described in chapter I), SFBT therapists could be categorized as relatively centered and influential.

### **Part Two: Outcome Studies and Therapeutic Relationship or Alliance**

In the first part of the literature review, I explored the position of the therapist in many different psychotherapy approaches and categorized their positions based on White's matrix on position of the therapist as described in chapter I. This categorization is open to discussion and is based on my extensive exploration of each model's underlying assumptions, presuppositions, intentions, and mainly looking at what therapists using their particular models think and do in the process of therapy. In



addition, this categorization of the position of the therapist is based not only on how they describe their stance in their theory, but also on more critical examination of how they view clients, how they conceptualize clients' problems, and how they intervene to create a difference that they believe will make a difference. Looking at the therapeutic relationship and position of the therapist in isolation without exploring the therapist's intentions, beliefs, and practices is a very limited view that is here intentionally avoided. In this second part of this chapter, the review of research findings on therapeutic relationship and psychotherapy outcome is presented.

Exploring how therapeutic relationships are established and maintained between the therapist and their clients is important because many studies have found correlations between the stronger therapeutic alliances and clients' progress (e.g., Arnow et al., 2013; Brown & O'Leary, 2000; Bourgeois, Sabourin, & Wright, 1990; Horvath & Symonds, 1991; Johnson & Talitman, 1997; Johnson, Wright, & Ketring, 2002; Johnson & Ketring, 2006; Kazdin, Marciano, & Whitley, 2005; Knobloch-Fedders, Pinsof, & Mann, 2007; Shelef, Diamond, Diamon, & Liddle, 2005). On the other hand, many studies found the relationship between a weaker therapeutic alliances and clients' dropout from treatment (e.g. Robbins et al., 2008; Robbins et al., 2006; Robbins, Turner, Alexander, & Perez, 2003; Sharf, Primavera, & Diener, 2010). Furthermore, there are no studies exploring how therapeutic relationships are created in narrative therapy using a de-centered and influential position.

A study by Arnow et al. (2013) explored the relationship between the therapeutic alliance and treatment outcome in two distinct manualized psychotherapies for depression (cognitive behavioral analysis system of psychotherapy (CBASP) and brief supportive

psychotherapy (BSP)) that were administered, in addition with antidepressants, to outpatient participants who met the criteria for major depressive disorder. Arnow et al. found that early higher scores on therapeutic alliance as reported by participants were significantly associated with subsequent reduction of depression symptoms over 12 weeks treatment. They also found that therapeutic alliance was more strongly related to outcome in cognitive behavioral analysis system psychotherapy than brief supportive psychotherapy.

Brown and O'Leary (2000) examined the relationship between the therapeutic alliance and psychological and physical violence in "husband-to-wife violent couples" that attended 14 weeks group treatment, weekly for 2 hours, and received either conjoint or gender-specific cognitive-behavioral group therapy that was presented in psycho-educational format. The observers, researchers assessed the therapeutic alliances using the Working Alliance Inventory, which includes three subscales: bond between the therapist and the client, agreement on goals, and agreement on tasks. Brown and O'Leary found that strength of husbands' therapeutic alliance was positively associated with treatment outcomes: decreased mild and severe physical and psychological aggression. They concluded that when working with couples in which men are violent toward women it seems to be important to establish a positive working relationship with the husband more than the wife.

A study by Bourgeois, Sabourin, and Wright (1990) also looked at therapeutic alliance as a predictor of positive outcome in group marital therapy with couples who reported marital distress at the beginning of 9 week treatment during which they were taught how to communicate better using active listening, learning how to express their

positive and negative feelings, how to problem solve, and how to fight constructively.

Therapeutic alliance was measured after the third therapy session by therapist and clients separately. In addition, couples completed pre and post treatment Dyadic Adjustment Scale, the Potential Problem Checklist, Marital Happiness Scale, and Problem Solving Inventory. Bourgeois et al. found that marital distress at the beginning of the treatment was not significantly related to quality of therapeutic alliance measured after 3 weeks; however, therapeutic alliance was a significant predictor of successful outcome after 9 weeks. As in Brown and O'Leary (2000) study, Bourgeois et al. found that the stronger therapeutic alliance was more important precursor for positive treatment outcome in males than females. For females, therapeutic alliance accounted for 5 percent of the variance on Dyadic Adjustment Scale at the end of the treatment, while for males therapeutic alliance accounted for 7 percent of the variance in scores on Dyadic Adjustment Scale, 5 percent of the variance in the Marital Happiness Scale, and 8 percent of variance in Potential Problem Checklist scores.

Knobloch-Fedders, Pinsof, and Mann (2007) investigated the relationship between therapeutic alliance and treatment progress in couples conjoint therapy from session 1 to session 8. Treatment was not time limited and was conducted using integrative problem-centered therapy. Although therapeutic alliance was not related to improvement in individual functioning, it was found that therapeutic alliance was a strong predictor for improvement in marital distress over time accounting for 5-22% of variance. Knobloch-Fedders et al. also found that couples who completed 8 sessions had reported stronger early therapeutic alliances with their therapists (after session 1) than couples who dropped out from the treatment earlier. The first session therapeutic alliance

was also linked to completion of conjoint treatment for alcohol abuse and dependence using three different treatment modalities: Alcohol Behavioral Marital Therapy (ABMT), Alcohol Anonymous plus ABMT, and Relapse Prevention plus ABMT (Raytek, McCrady, Epstein, & Hirsch, 1999). The raters who observed therapists behavior related to therapeutic alliance in video taped sessions found that therapists who were more experienced and who delivered treatment more competently (with fewer errors) were able to develop a stronger therapeutic alliances (Raytek et al., 1999). Raytek et al. (1999) conducted also a qualitative analysis of therapists' behavior and suggested certain characteristics how experienced therapists conducted their sessions.

They were very interactive with the couples throughout the sessions, asking open-ended questions, acknowledging and responding empathically to comments, and addressing issues that the clients initiated. The therapists also addressed both members of the couple, often checking in with each partner about his/her reaction to what the other person had said. Throughout the session, the experienced therapists addressed the topics from the manual in a flexible and personalized manner. In addressing the first session topics, the experienced therapists used discussion framework in which they focused on the reactions of each member of the couple to what was being discussed. The therapists were able to achieve a good balance between covering the necessary material and being open to the concerns of the couple. (pp. 326-327)

Therapeutic alliance was found to predict a successful outcome in Emotionally Focused Marital therapy with moderately distressed couples (Johnson & Talitman, 1997). Johnson and Talitman measured couples therapy alliance after third session in their 12-

week treatment study using EFT approach. These researchers found that strong therapeutic alliance, that was measured after third session, accounted for 22 percent of the variance in marital satisfaction at termination of treatment after 12 sessions and 29 percent of the variance in marital satisfaction as measured at 3-month follow up. Couples who experienced strong therapeutic alliances also reported higher levels of intimacy at the end of treatment. Johnson and Talitman (1997) showed that when practicing Emotionally Focused Marital Therapy therapists need to focus on building therapeutic alliances with couples, and to make sure that the task of therapy is relevant to the couple's presenting problems as perceived by couple.

In addition to exploring therapeutic alliance in individual and couples therapy, the relationship between therapeutic alliance and treatment outcome was investigated in family therapy with different presenting problems. For example, Shelef, Diamond, Diamon, and Liddle (2005) studied adolescents who abused substances and their families using multidimensional family therapy in a 12-week long treatment. The train alliance raters observed video session segments and measured adolescent-therapist and parent-therapist alliances using Vanderbilt Therapeutic Alliance Scale. In addition, adolescents completed the Working Alliance Inventory once between sessions 3 and 5 reporting their perceptions of adolescent-therapist alliance. Shelef et al. (2005) found that adolescent alliance predicted fewer problems with substance abuse and dependency symptoms at the end of treatment. They also found that the strength of parental alliances moderated relationship between adolescent alliance and treatment outcome as well as predicted premature termination when parent-therapist alliance was low.

Another study by Johnson and Ketring (2006) examined therapeutic alliance as a moderator in therapy outcome for families dealing with child abuse and neglect. Participants in this study received a home-based ecosystemic therapy, initially twice weekly for 6 to 8 weeks, and then once weekly (on average families received 19.1 sessions). They completed Family Therapy Alliance Scale at the end of treatment, and Conflict Tactics Scale and Outcome Questionnaire at the pre- and post-treatment. Johnson and Ketring (2006) found significant relationship between pre-test reported violence and bonds subscale in therapeutic alliance, suggesting that when the violence is greater at the beginning of the treatment a therapist needs to develop a stronger bond and trusting relationships with family members in order to facilitate change. Johnson and Ketring suggested that alliance is related to symptoms of distress and violence at the end of their ecosystemic therapy. Therefore, therapeutic alliance is an important factor of change in family therapy.

Kazdin, Marciano, and Whitley (2005) studied therapeutic alliance in cognitive behavioral treatment of children (ages 3-14) referred for oppositional, aggressive, and antisocial behavior. The relationship with the therapist was measured in this study from therapist's, child's, and parents' perspective using the Therapeutic Alliance Scale for Children and the Working Alliance Inventory. They also completed the Treatment Improvement Scale, the Barriers to Treatment Participation Scale, the Treatment Evaluation Inventory to measure the outcomes of accessibility of treatment, barriers to participation in treatment, and changes in child deviant behavior. Kazdin et al. found that the stronger child-therapist and parent-therapist alliances, the greater therapeutic changes on measures of child improvements at the end of family therapy (12-session treatment) as

reported by the therapist, parent, and child. The stronger therapeutic alliances were also related to more acceptable views of techniques by parents and children and fewer perceived barriers in treatment.

Johnson, Wright, and Ketrang (2002) investigated therapeutic alliance in family therapy with children who experienced abuse, neglect, and/or juvenile offences. Families were in treatment for 14.3 weeks on average and were seen by co-therapy team, that included their therapist and their case manager who worked with families to resolve their issues such as child abuse and neglect, lack of family rules, family structure issues, depression, marital difficulties, financial problems, drug use, and depression. At the end of treatment, family members completed the Family Therapy Alliance Scale among other outcome measures designed for symptom distress, family coping, and interpersonal relationships. Johnson et al.'s regression analysis revealed that the therapeutic alliance accounted for 19 percent of the variance in symptom reduction for mothers, 39 percent of the variance in symptom reduction for adolescents, and 55 percent of variance in symptom reduction for fathers. Johnson et al. (2002) concluded:

The findings of this study suggest that therapists also may benefit from augmenting their skills in specific interventions with skills specific to enhancing the therapeutic alliance. To some extent enhancing one's skills related to the therapeutic alliance is a matter of focusing less on techniques and more on the basic and time-honored therapist-client relationship. However, relationship skills really go beyond enhancing therapist-child interactions through classic notions of effective listening and demonstrating positive regard. What must be facilitated is a process whereby family members and the therapist develop into a collaborative

team in which there is a sense of agreement what needs to be done and how it is to be done. (p. 99)

Although many studies reviewed above suggest that strong therapeutic alliance predicts successful outcomes in individual, couples, and family therapy, it is unclear how alliances are created. Horvath and Symonds (1991) suggested also that the relationship between the therapist and the client is described in literature as “working,” “helping,” or “therapeutic” alliance. In addition, they explained how the concept of alliance evolved over time in research studies depending on the different theoretical orientations. Gaston (1990) also explained different definitions of alliance through different theoretical perspectives. Review of research studies on therapeutic alliance and outcome reveals that therapeutic alliances could be measured by clients, therapists, and raters at different times in treatment (early or at the end of treatment) using different scales and inventories (Horvath & Symonds, 1991). Horvath and Symonds’s meta-analysis of 24 studies found that working alliance is a moderate but reliable predictor of positive therapy outcome and that the clients’ reports are the most reliable assessment for such prediction.

Therapeutic alliances were also studied in relations to drop out in different family therapies. For example, Robbins, Turner, Alexander, and Perez (2003) found that unbalanced alliances in functional family therapy for adolescents with behavioral problems are significantly associated with dropout in therapy. Unbalanced alliances between the therapist and the family members, rather than overall level of alliance predicted dropout. Robbins et al. used trained raters to rate adolescent-therapist and parent-therapist alliances in their first video session. The results of this study suggest that family therapists need to avoid coalitions and “must remain cognizant of these potential



traps and intervene in a manner that is sensitive to the unique characteristics of individual family members as well as to the complex interactions of the family system” (Robbins et al., 2003, p. 541). Robbins et al. suggested that, “therapists in the dropout cases may have inadequately validated parental negativity about the adolescent without adequately responding to the adolescent’s needs or concerns.” (p. 541)

According to Robbins et al. (2006), weaker therapeutic alliances in the first two therapy sessions were also significantly associated with dropout from multidimensional family therapy with mothers and their adolescents who abuse drugs. Compared to families who had completed the treatment, dropout families experienced decline in both parent-therapist and adolescent therapist alliances over the first two sessions. Robbins et al. (2006) suggested that, “how the intervention is done appears to be more important than who does the intervention” (p. 114). The relationship between adolescent and parent therapeutic alliances in first sessions and retention in family therapy with drug-using Hispanic adolescents was also explored using a brief strategic family therapy (Robbins et al., 2008). As predicted, Robbins et al. found that families who completed the brief strategic family therapy had statistically significantly higher level of alliance as rated by trained raters on Vanderbilt Therapeutic Alliance Scale-Revised than families who dropped out (as judged by their therapist and attending less than eight sessions). As in Robbins et al.’s (2003) study, Robbins et al.’s (2008) study found that unbalanced alliances predicted dropouts. More specifically, mother-adolescent unbalanced alliances with therapist were significantly predictive of dropout.

Given that therapeutic relationships affect the retention and the outcome of treatment as cited above, studying qualitatively how these alliances or relationships are

created is a useful research goal. This study will particularly focus on the relationship between the therapist and the client in narrative therapy by exploring how Michael White, taking a decentered and influential position interacts with his clients. The focus is more on narrative therapist since clients tend to see psychotherapists as having a primarily responsibility for creating therapeutic alliances (e.g., Bedi, Davis, & Williams, 2005). Studies (e.g., Kivlighan, 1990; Mohr & Woodhouse, 2001) suggested that techniques or/and therapist's interventions cannot be separated from the context of the relationship and were perceived to influence alliance by clients (as cited in Bedi, Davis, & Williams, 2005). Therefore, what therapist does and say during sessions influences the outcomes and is based on their worldview and position that they take in a relationship with their clients. There is no research (known to this researcher) that explored how a narrative therapist takes a decentered and influential position in relationships with clients.

### **Part Three: Narrative Therapy**

Narrative therapy was developed by a social worker Michael White from Adelaide Australia, and David Epston from New Zealand in 1980s. According to Cheryl White, narrative therapy practice was informed and influenced initially by social movements such as anti-Vietnam War protest and feminist movement in which people questioned and challenged authorities. Later, Michael White “became determined to challenge and put forward alternatives to the taken-for-granted authorities within mental health services and psychiatry” (White, 2011, p. 159). Cheryl White explained that,

As people in many different countries became determined to alter the ways in which their societies responded to those in social and emotional distress, this

became a passion in Michael's life. And it is this commitment that led to the development of what is now known as narrative therapy. (White, 2011, p. 159)

Michael White stressed that narrative therapy was developed as a result of his co-research with the people whom he consulted and his readings from outside the field, which includes writings of Bateson, Foucault, Bruner, Myerhoff, Vygotsky, Derrida, Deluze, and others (White, 2011). His thinking was influenced by feminist theory, literary theory, anthropology, and critical theory that helps us, according to White, "to consider the various ways that we are, or might be, reproducing dominant culture within the therapeutic discipline...and to consider how various aspects of this cultural reproduction might not be so helpful to those persons who seek our help" (White, 1995, p. 12). White believed that this critical reflection of our work and our field increases our awareness of the effects of these ways of thinking and acting with people who consult us and therefore, "it becomes possible for us to take responsibility for the real effects of our work on the lives of those persons who seek our help" (White, 1995, p. 13). White (2007) strongly believed that, "As therapists, we are responsible for the consequences of what we do, say, and think." (p. 31).

### **Narrative Therapy Worldview**

Narrative therapy, in contrast to many other models of psychotherapy, shifted from structuralism and positivism to post-structuralism and social constructionism view of understanding the world and human behavior. To clarify differences,

Positivism is an approach to the understanding of events in the world that proposes that it is possible to directly know the world – that it is possible for observers of certain phenomena to gain an objective knowledge of reality, to

identify “brute facts,” and to uncover the “truth” of the world. Positivism, in its attempts to come up with these truths, employs a reductionist method: It consistently endeavors to reduce the complexity of phenomena to basic elements, which are then considered to be the building blocks of the phenomena in question. These elements can be categorized and classified, and universal laws governing such phenomena in all places and at all times can be “discovered.” (White, 2011, pp. 149-150)

When positivism was applied to the human sciences, persons were subjected to the assessment of observers, armed with the techniques of evaluation, who were considered to be objective and thus not implicated in the construction of the realities being brought forth. Complex phenomena, as reflected in human behavior, were reduced to the building blocks of that behavior – such as certain traits, drives, needs, complexes of desire, etc. Behavior and social organization, considered to be in some way problematic, were assessed to be disorders in these basic elements, disorders that could be categorized and then classified. In this way, classification could represent the truth of the person. (White, 2011, p. 150)

It appears that the position of the therapist with a positivist and structuralist orientation is “centered” (White, 2007) or that of an expert, who can objectively assess for “abnormalities” and treat people’s “defective” personalities. This view can be seen in many first order cybernetic models in which therapists are trying to repair or fix people (as machines) by being objective experts who know what is needed for the family to be more functional. White disagreed with this view and practice. He agreed with Maturana

and others who said, “Observer in, objectivity out,” which means that a therapist is part of the system and cannot be an objective observer (White, 1986b).

Positivism thrives on the idea that “human behavior and social organization reflect, in various ways, the structure of the mind or the emotional system” (White, 2011, p. 150). Examples of these include, but are not limited to, ideas of irrational thoughts in cognitive therapy, anxiety and differentiation of self in Bowen theory, different boundaries in structural therapy, diagnostic statistic manuals, and etc. White (2011) believed that therapists informed by positivism or structuralism employ remedy methods that actually “engage people in internalizing discourses” (p. 150) which in a way may convince people that the problems in their lives are a reflection of their defective “selves” which is supported by therapists’ theoretical assumptions and cultural norms.

In addition, White (2011) believed that it is our responsibility to refuse to engage “in the politics of totalization and marginalization of person’s lives... and to refuse to enter into the ever-expanding discourses of psychopathology that so saturate the culture of therapy” (p. 64). White (2011) argued that,

To engage in these expert internalizing discourses of psychopathology is political in several senses. First, in that these discourses internalize the locus of problems that persons bring to therapy, they erase the historical forces that are constitutive of these problems, and they deny a political analysis of the context that is constitutive of the problem... This has the effect of incapacitating those persons who seek our help. The pathologizing of life subtracts from personal agency. It has the effect of privileging the expert knowledges and disqualifying the knowledges of those persons who seek our help. (p. 64)

White (2011) pointed out that the expert discourses on psychopathology lead to exclusions, discrimination, marginalization, oppression, obscuring relational politics, perpetuating inequality of opportunity, preserving hierarchy of knowledge and power, and so forth. White suggested that,

The psychologization of life that is achieved by the professional knowledges supports the assumption of therapist objectivity and preserves the myth of therapists impartiality, detachment, and neutrality. This psychologization of life is achieved through a network of universal truth claims that obscures the extent to which professional knowledges are culture-specific and the extent to which they are manufactured through specific historical and political processes. (White, 2011, pp. 65-66)

### **Post-structuralism**

In his critique of structuralist discourses on human nature, White (1997) described the effects of “the will to truth, the repressive hypothesis, and the emancipation narrative” (p. 220) on therapeutic practice. These effects include:

- 1) The confirmation of the known or reproducing culturally venerated ways of thinking and being; in other words, arriving at thin descriptions of our lives.
- 2) Obscuring acts of meaning, which rules out “the possibility for us to join with persons in the exploration of alternative meanings that contradict those that are routinely reproduced in their lives” (p. 226); which “renders invisible the extent to which persons are active in the shaping of their lives as they live their lives” (p. 226); and which “rules out options for us to acknowledge our own participation in

the negotiation of meaning, in the shaping of the lives of the persons who consult us” (p. 227)

- 3) Constrained lives and constraining of therapeutic interactions by narrowing options for other ways of thinking and being. The “commitment to this question of ‘truth’ is significantly limiting of the possibilities in regard to our ways of being with the persons who consult us.” (p. 228)

- 4) The marginalization of ethics and possible negative effects of the power relation of therapy. White explained that,

When therapy is established as a context for the identification and expression of the truths of human nature, success is determined by the extent to which therapy contributes to things being as they ideally should be in the lives of persons who consult therapists- by the extent to which persons have arrived at the point at which their lives reflect the states of being that are expressions of the norms, rules and laws of nature. (p. 228)

- 5) Concealing the power-knowledge relation.

When this link between knowledge and power is obscured, it becomes impossible for us, as therapists, to identify the ways in which the “truths” of human nature are taken up in relations of power, and to establish therapy as a context for reviewing the real effects of these power relations. (p. 229)

- 6) The dissolution of history which limits focus on “deficit-centered or problem-saturated accounts of history” (p. 230). This is based on belief that,

In order that person might become free to be who they truly are, history is something to be undone, to be resolved. And in that the outcome of resolving the forces of history is the achievement of some ideal state.” (p. 229).

Poststructuralist writers and thinkers such as, Foucault, Derrida, Lacan, Deleuze, Lyotard etc. “reacted against the formalism of structuralist linguistics and against the figure of the epistemological subject implied or explicitly defended by its theorists” (Poster, 1989, p. 4).

Poststructuralists question the easy assumption that the theoretical subject can generate a discourse that represents the real, unmask domination in the real, without himself/herself introducing new forms of domination. Poststructuralists criticize the assumption of much of modern thought that theoretical discourse is a direct expression of a truth in the theorist’s mind, that this truth in some way captures historical reality, and that the question of freedom entails the appropriation of this truth by historical agents and their subsequent action to actualize it. Poststructuralists point to various ways in which language materially affects the relation of the theorist to his or her discourse and the ways in which the social field is composed of linguistic phenomena – Foucault’s discourse/practice, Baudrillard’s code, Derrida’s *écriture*, Lyotard’s phrases and *le différend*. (Poster, 1989, p. 4)

Poststructuralists believe that theory is “an epistemological attempt at conceptual clarification which spills over into a metaphysical gesture to regulate the terms of reality.



The theoretical concept places too much faith in the theorist's ability to make determinations, to fix identities, identities whose effect is political.” (Poster, 1989, p. 6)

The tendency in poststructuralism is therefore to regard truth as a multiplicity, to exult in the play of diverse meanings, in the continual processes of reinterpretation, in the contention of opposing claims. Accordingly, text replaces mind as the locus of enunciation, and difference replaces identity as strategy of reading. (Poster, 1989, p. 15)

While structuralists believe that people contain selves, personalities, traits, strengths and deficiencies that can be evaluated against some objective standards given that the therapist can be objective and discover the “truth,” post-structuralists believe in multiple realities and see people living their lives based on their intentions, purposes, values, goals, aspirations, commitments, dreams, etc. rather than behaving in a way that reflects their internal structures. According to the post-structuralist worldview, people are seen as being in a relationship with their problems rather than in possession of problems. They are seen as social and interpretive beings, rather than structures, who are active in construction of stories of their lives (J. Hibel, personal communication, 2011).

Narrative therapists take a post-structuralist view and de-centered position. They focus on identity conclusions and liberating people from oppressive internalized discourses that inhibit living their preferred identities in social context. It is a collaborative and respectful approach or inquiry that is very influential yet not imposing of therapists' beliefs and values, but instead exploring and respecting a person's preferences in re-authoring their lives. Narrative therapists listen for, and are interested in, people's hopes, values, intentions, dreams, beliefs, goals, and aspirations (White,

2007). They are interested in meaning rather than problem solving and they try “to bring forth and thicken stories that did not support or sustain problems” (Freedman & Combs, 1996, p. 16).

White (2007) believed that people’s actions are shaped by their values, purposes, hopes, dreams, intentions, aspirations and commitments rather than the essence of their identities or their true selves. His post-structuralist view can be seen in re-authoring conversation practice where he explained the difference between “internal state understandings” and “intentional state understandings” which he preferred.

Internal state understandings portray human action as a surface manifestation of specific elements or essences of a self that is to be “found” at the center of his identity. For example, in the context of internal state understandings, human expression might be interpreted as a manifestation of any number of unconscious motives, instincts, needs, desires, drives, dispositions, personality traits, personal properties (like strengths and recourses), and so on. (White, 2007, p. 101)

White (2007) believed that this way of thinking and evolution of the concept of “self” represents, in a way, “a new system of social control in which ‘normalizing judgment’ steadily displaced moral judgment’ (p. 102) and that it leads to a creation of so called “distortions,” “dysfunctions,” or “disorders” when a person is not meeting an ideal, culturally preferred standards of what it means to be “functional,” “healthy” and so forth. In addition, White (2007) stated that internal understandings tend to diminish sense of personal agency, tend to be isolating, and tend to discourage diversity.

In contrast to internal state conceptions, intentional state conceptions of identity are distinguished by the notion of “personal agency.” This notion casts people as

active mediators and negotiators of life's meanings and predicaments, both individually and in collaboration with others...People are living their lives according to intentions that they embrace in the pursuit of what they give value to in life. (White, 2007, p. 103)

Narrative therapy is based on a premise that identity conclusions, what people believe about themselves and about their relationships, significantly influence their actions; in other words, they shape their lives. And these conclusions are also associated with dominant cultural stories that people are born and live in (White, 2007; Freedman & Combs, 1996).

### **Social Construction**

In addition to post-structuralist worldview, narrative therapy was also described as having a postmodern, narrative, social constructionist, and constitutionalist view on reality, power, knowledge, objectivity, "truth," "self," and this worldview forms how they see people's problems and how they position themselves to create relationships with people who consult them.

White (1993) explained that his constitutionalist perspective rejects essentialism, representationalism, and foundationalist assumptions of objectivity, and proposes that "an objective knowledge of the world is not possible, that knowledges are actually generated in particular discursive fields...And that constitutionalist perspective proposes that the descriptions do not correspond with the world, but have real effects on the shaping of life" (p. 125). This perspective puts therapists in a not-knowing, not-expert, and de-centered position when working with people who come to consult them. Narrative therapists do not try to discover the truth or look for pathologies based on some cultural

values what it means to be normal, rather they are interested and curious about people's positions on their lives and what they value, hope for, and aspire for their lives.

Freedman and Combs (1996) described social constructionist worldview by stressing four ideas. "These ideas are: 1. Realities are socially constructed.

2. Realities are constructed through language. 3. Realities are organized and maintained through narrative. 4. There are no essential truths." (Freedman & Combs, 1996, p. 22).

What the first idea means is that people construct their realities in relationships with each other, in social interactions over time. What they initially have decided, over generations and time, became unquestionable truth or reality. Gergen (2009) said that, "social constructionists locate the origin of meaning in relationships" (p.26), not in the mind of the individual what constructivists do. Thus, in a social constructionist view the focus is not on an individual mind, but instead, on "how people interact with one another to construct, modify, and maintain what their society holds to be true, real, and meaningful" (Freedman & Combs, 1996, p. 27). Hoffman (1992) explained that, "Social constructionists hold firmly to the idea that there are no inconvertible social truths, only stories about the world that we tell ourselves and others" (p. 19).

The second idea, that "realities are constructed through language," means that "our language tells us how to see the world and what to see in it" (Freedman & Combs, 1996, p. 28). It does not mean that through language we can know the real world, as it is out there, but rather that the language creates the world we know. Bruner (2004) cited Slobin who said that,

One cannot verbalize experience without taking a perspective, and...the language being used often favors particular perspectives. The world does not present

‘events’ to be encoded in language. Rather, in the process of speaking or writing, experiences are filtered through language into verbalized events. (p. 7)

Also, that realities are constructed through language means that change, “whether it be change of belief, relationship, feeling, or self-concept, involves change in language” (Freedman & Combs, 1996, p. 29). Narrative therapists work with people not to change them or fix their problems, but to help them create more preferred stories that can be transformative.

The third idea of social construction worldview means that, “If realities we inhabit are brought forth in the language we use, they are then kept alive and passed along in the stories that we live and tell” (Freedman & Combs, 1996, pp. 29-30). White and Epston (1990) said that,

In striving to make sense of life, persons face the task of arranging their experiences of events in sequences across time in such a way to arrive at a coherent account of themselves and the world around them... This account can be referred to as a story or self-narrative. The success of this storying of experience provides persons with a sense of continuity and meaning in their lives, and this is relied upon the ordering of daily lives and for interpretation of further experiences. (p. 10)

Bruner (2004) argued that, “it is through narrative that we create and recreate selfhood, that self is a product of our telling and not some essence to be delved for in the recesses of subjectivity.” (p. 13). He also believed that, “Stories become transformative only in their performance” (as cited in, Freedman & Combs, 1996, p. 33).

People make sense of their lives through stories, both cultural narratives they are born into and the personal narratives they construct in relation to the cultural narratives. In any culture, certain narratives will come to be dominant over other narratives. These dominant narratives will specify the preferred and customary ways of believing and behaving within the particular culture. (Freedman & Combs, 1996, p. 32)

This means that certain dominant narratives can be oppressive for people who seek consultation because, for example, they may ascribe meaning to certain events in their lives based on comparison with cultural norms; certain dominant stories discriminate and marginalize minority groups; and every self-narrative has events that don't get "storied" and therefore new meanings can be constructed by exploration and reflection on those events or unique outcomes in dominant story. Narrative therapists are interested in the "local knowledge" of each person in order to understand how dominant cultural stories influence them (Freedman & Combs, 1996). "Narrative therapy is about the retelling and reliving of stories" (Freedman & Combs, 1996, p. 33).

Finally, the idea that "there are no essential truths" in social construction worldview implies that there are many possibilities how an experience can be interpreted rather than one, and that there is no "essential self" because "self" according to social construction is created in interaction with others through language. Narrative therapists "think of self not as a thing inside an individual, but as a process or activity that occurs in the space between people" (Freedman & Combs, 1996, p. 34). It is seen as a performance in context rather than as an internal structure (as it is in structuralism). According to social construction view, as described by Freedman and Combs (1996):

Different selves come forth in different contexts and no one self is truer than any other. We think that people are continually constituting each other's "selves," and that there are many possible stories about my-self, and your-self, and other people's selves...Instead of looking for an essential self, we work with people to bring forth various experiences of self and to distinguish which of those selves they prefer in which contexts. We then work to assist them in living out narratives that support the growth and development of these "preferred selves." (p. 35)

Bruner (2004) suggested that,

There is no such thing as an intuitively obvious and essential self to know, one that just sits there ready to be portrayed in words. Rather, we constantly construct and reconstruct our selves to meet the needs of the situations we encountered, and we do so with the guidance of our memories of the past and our hopes and fears for the future. (p. 4)

### **Narrative Metaphor**

Unlike many family therapy models that are guided by the metaphor of "systems," narrative therapy uses the metaphor of narrative as an interpretive method. It proposes that, "human beings are interpretive beings – that we are active in the interpretation of our experiences as we live our lives" (White, 1995, p. 13). Narrative metaphor is focused on meaning; how people interpret their experiences.

It is the narrative or story that provides the primary frame for this interpretation, for the activity of meaning-making...it is through the narratives or the stories that persons have about their own lives and the lives of others that they make sense of their experience. Not only do these stories determine the meaning that persons

give to experience...but these stories also largely determine which aspects of experience persons select out for expression. (White, 1992, p. 123)

Narrative metaphor does not propose that stories are a reflection or mirror of life as it is. “Instead, the narrative metaphor proposes that persons live their lives by stories – that these stories are shaping of life, and that they have real, not imagined effects – and that these stories provide the structure of life.” (White, 1992, p. 123)

White “saw in the narrative metaphor that a story is a map that extends through time” (Freedman & Combs, 1996, p. 15). Initially, White was influenced by Bateson’s discovery that time plays a role in perception of difference and change; however, later he expanded his thinking about narrative metaphor by studying Jerome Bruner’s analysis of literary texts. Bruner proposed that stories are composed of dual landscapes: a) a landscape of action, that is composed of events that are linked in sequence through time according to specific plot and which “provides reader with a perspective on the thematic unfolding of events across time,” and, b) a landscape of consciousness, that is composed of “the reflection on the events of the landscape of action” (p. 78), meaning-making, intentions, purposes, conclusions about the identity, and so forth (as cited in White, 2007). White (2007) saw parallels between “the structure of literary text and structure of meaning-making in everyday life” and “between the literary text and structure of therapeutic practice” (p. 80). White used this dual landscape structure in his re-authoring practices and renamed the concept of “landscape of consciousness” with “landscape of identity.”

White (2007) noticed that the concepts of landscapes are relevant to the therapeutic task, which he believed to be, “redevelopment of personal stories and the



reconstruction of the identity” (p. 80). Given that every story has gaps and inconsistencies in both landscapes, White (2007) believed that therapists should focus on rich story development, to draw person’s attention to gaps in his/her “subordinate” storylines, to engage them “to fill in these gaps by stretching their minds, exercising their imagination, and recruiting their lived experience,” (p. 81) and give meaning to “many of overlooked but significant events of their lives” (p. 83). For example, he would ask them to reflect on neglected events of their lives that are not predicted by their dominant problem-saturated story, which can lead to development of preferred stories.

De-centered position of the therapist can be evident in that, compared to authors of literary text,

therapists are not the originators of the storyline that is developed in the therapeutic conversation...they are not primary author in the sense the author of a literary text is. Rather, therapists privilege the voices of the people consulting them in attribution of meaning to selected events in their lives, in their interpretation of the links between these events and the valued themes of their lives, in their deduction about what this reflects in terms of what is important to them, and in their conclusions about what this suggests about their own and each other’s identities. (White, 2007, p. 82)

White (1995) suggested that narrative metaphor,

requires that the therapist challenges his/her settled certainties. S/he can’t know, in advance, what’s “right” for people – can’t even know how the family “should” look at the end of therapy. The narrative metaphor challenges totalizing practices. It encourages the therapist to enter into a reflexive position in relation to the

constitution of therapeutic realities. And it encourages the therapist to assist those persons who see therapy to enter into a similar position in relation to their own lives and, as well, to engage in the re-authoring of their lives according to alternative and preferred stories about who they might be. (p. 66)

## **Foucault**

White (1995) said that Foucault's ideas were the most influential in his thinking. Michel Foucault, a French intellectual and "historian of systems of thought," studied, among other things, history of mental illness and how people were categorized as "abnormal" and "normal." Foucault showed that the definitions of mental illness, madness, criminality, and sexuality differed throughout the history of mankind and were defined by powerful minority (Fillingham, 1993). Some examples of these mental illnesses that are no longer considered mental illnesses include but are not limited to: leprosy, hysteria in women, homosexuality, and so on. Foucault (1971) said that, "We forget certain problems and create new ones." These psychiatric labels were used to dehumanize and to torture people in history and to regulate behavior.

To Foucault language is an instrument of power... He argues that there is inseparable link between knowledge and power: the discourses of a society determine what knowledge is held to be true, right, or proper in that society, so those who control the discourse control the knowledge... To Foucault, power is knowledge and knowledge is power. (Freedman & Combs, 1996, pp. 37-38)

Thus, those in power are "able to impose their idea of the right, or the true, on the majority" (Fillingham, 1993, p. 7), which often has dehumanizing and oppressive consequences.

Foucault showed how cultural practices of objectification of persons and their bodies were used to extend and enhance the social control, to subjugate, to divide, and exclude certain people by ascription of identity with specifications for self-possession and self-containment (White, 1989). “In this objectification of identity, many of the problems that people encounter in life come to represent the “truth” of their identity” (White, 2007, p. 25). According to White (2007), “many of the problems that people consult therapists about are cultural in nature” (p. 25). People judge themselves based on dominant cultural stories and norms that they have internalized, which consequently leads to feelings of inadequacy, incompetence, deficiency, insufficiency, and so forth (White, 2002). White (2007) believed that, “dominant narratives tend to blind us to the possibilities that other narratives might offer us” (Freedman & Combs, 1996, p. 39). White (2002) also suggested that, “dramatic growth of the phenomenon of personal failure is associated with the rise of a distinctly modern version of power that establishes an effective system of social control through what can be referred as “normalizing judgment” (p. 43).

Foucault’s analysis of Jeremy Bentham’s Panopticon led to the concept of modern power (White, 1989). The Panopticon was an architectural invention of eighteenth century designed for invisible surveillance of prisoners from the top of the tower, which was located in the center of a prison’s courtyard. The structure and organization of the panopticon were such that prisoners could not see whether or not the guardian was observing them from the tower, although prisoners were always visible to guardians. These factors increased a prisoner’s feelings of isolation and powerlessness and lead to behaving as if he or she was observed at all times. Therefore, a prisoner becomes his or

her own guardian in controlling his or her behavior. “The Panopticon was a model for complete and successful subjugation of persons...a particularly modern system of power that that relies on normalizing judgment (White, 1989, p. 24). White (1989) explained that,

This modern system of power is one that not only renders persons and their bodies as objects, but it is also one that recruits persons into an active role in their own subjugation; into actively participating in operations that shape their lives according to the norms or specifications of the organization. (p. 25)

White (1989) further explained Foucault’s analysis of how the Panopticon model of achieving order, obedience, and social control shaped people’s behavior:

Under these conditions they would become ever-vigilant with regard to their behaviour, evaluating all actions and gestures against the norms that are specified by the particular organization. And upon identifying any anomalies or aberrations in their own conduct, they would be induced to relate to their own bodies as objects: to engage in disciplinary and corrective operations to forge their own bodies as docile. Thus, they became their own guardians. They policed their own gestures. And they became the objects of their own scrutiny. (p. 25)

Foucault argues that “now we have a society of normalization in which evaluation has replaced torture, and has infiltrated the judiciary in matters of social control; in control of bodies, or groups, and of knowledge” (White, 1989, p. 27). White was critical of reproducing dominant discourse and normalizing judgment in therapy. He believed that “many of the problems that people consult therapists about are cultural in nature” (White,

2007, p. 25) and that, “dominant narratives tend to blind us to the possibilities that other narrative might offer us” (Freedman & Combs, 1996, p. 39).

White (2011) expressed his values and beliefs about the role of the therapist by asking the following questions:

Is it our role to be unwitting accomplices of modern power, or is it our role to sponsor diversity in everyday life? Is it our role to promote single-storied conceptions of life – or to bring forth complexity in the sense of alternative stories of life? Is the therapy room context for the confirmation of the known and familiar, or is it a context for arriving at what it might be possible to know? Is it a context for domesticating the exotic, or is it a context for “exoticizing” the domestic? (p. 43)

It can be concluded that Foucault influenced White in developing counter-practices to those in traditional psychotherapies, in seeing limitations of “expert knowledges,” in being aware of the power differential in therapy, in increased accountability for our actions, in bringing forth people’s voices and their preferences, in unmasking cultural discourses, in social justice issues, in personal agency and advocacy, among other things. White (1995) was aware that, “It is very easy for us to impose “truths,” because there is a power differential in our relations with those persons who seek help” (p. 30). White was interested in “what persons determine to be preferred ways of living and interacting with themselves and each other” and to help them, “to step more into those stories that are judged, by them, to be preferred – to perform the alternative understandings or meanings that these alternative stories make possible” (White, 1995, p. 19). He was not interested

in taking a role of a social engineer who aims to fix people into becoming “normal.” Rather, he was taking a de-centered and influential position.

### **Bateson**

Narrative therapy was also influenced by Gregory Bateson’s ideas. White (1995) reported that Bateson’s “restraints of redundancy” introduced him “to interpretive structures and to meaning as the heartland of life as we know it” (p. 65). White (1986a) early on suggested that his thinking fits with Bateson’s “negative explanation” of the events; which means that, “events take their course because they are restrained from taking alternative courses” (p. 85). On the other hand, “positive explanation,” means that, “events take their course because there’s a reaction to an action” (White, 1986b, p. 3). White (1986b) said that,

Like Bateson, I believe that positive explanation is quite sufficient to explain what happens on a billiard table, but not really sufficient to explain what is happening in human systems...When I am thinking about problems that families, couples, or individuals might have, I think about restraints.” (pp. 3-5)

White (1986a) defined restraints as “the network of presuppositions, premises, and expectations that make up the family members’ map of the world and that establish rules for selection of information about perceived objects or events” (p. 85). These maps of the world also include values, beliefs, certain premises, etc. White (1986b) said that people are “able to respond to events out there that fit within their map in some way; and that which doesn’t fit with that map or that pattern gets lost” (p. 4). In other words, “The survival of news is dependent upon how it fits with network of presuppositions.

Information that does not have meaning in this context is “forgotten or blurred” (White, 1986a, p. 86).

According to Bateson, and White (1986b) agreed, “in the world of non-living, notions of force, impact, etc. provide a sufficient explanation for events...And in this world, quantity is critical.”(p. 9) However, in the world of living “events are much dependent on restraints and also on information about difference...So when there is some new response, it’s always a response to information about difference...The recipient sees difference and responds to that difference” (p. 9).

White (1986b) stressed that therapists would intervene differently depending on how they see the world. In positive explanation therapists take an expert stance and look for what causes the problem and how to get rid of it or reduce its quantity, which could put blame and categorize individuals, couples and families as “dysfunctional” and “mentally disordered.” White using negative explanation would think of, “What is restraining this person from finding a different direction in life?” which can put him in de-centered and non-expert position. In the world of negative explanation: therapists look for the description of the problem, not theory about the problem; therapists co-evolve with the family to come up with new ideas and descriptions or to discover something new; the therapist job is to notice what is new and how that can endure; he or she does not give interventions at the end of the session; they are much less normative and they challenge their own biases (White, 1986b).

White (1986b) believed that “symptom itself is a restraint, rather than serving some function. He also believed that the therapist could join the family system without

positively connoting the problem, but instead by externalizing the problem. White (1986a) said that,

To assist families that have been unsuccessful in the discovery of new solution, the therapist joins with family members to form the therapeutic system, contributes to this system's readiness via the introduction of a new 'code book' that allows new ideas to be selected out, establishes conditions for double description in order that new distinctions can be drawn, and interviews in ways that contribute to the endurance or survival of new ideas. Thus, the therapist assists new ideas to ripple longer than old ideas. In this therapy, the therapist participates in the creation of a context for adventure and discovery. (p. 87)

In addition to adopting negative explanation of the world and exploring the restraints, White (1986a) took from Bateson ideas about double description. White (1986a) suggested that,

Receipt of news of difference requires that family members perceive a contrast between two or multiple descriptions. The therapist contributes to the family's perception of such contrasts by working to develop double or multiple descriptions of certain events, standing these descriptions side by side for family members and then inviting them to draw distinctions between these descriptions. This provides news of "difference which makes a difference" (Bateson 1972, p. 453) (p. 88)

White (1986a) developed multiple ways to create the context for double description. For example, by asking relative influence questions, he is asking family members to think about the ways in which not only the problem affected their lives, but also, how they



influenced the life of the problem. Additional examples of how he was creating a context for double description include: collapsing time, raising dilemmas, predicting relapses, and etc. (White, 1986a). White demonstrated that Bateson's notions of negative explanation, restraint, and double description influenced his initial work and how these ideas were successful in treatment for childhood fears and obsessive and compulsive behavior, as well as eating disorders (White, 1986a; White, 1986b).

### **Vygotsky**

From a Russian learning theorist, Lev Vygotsky, White used and “applied the metaphor of ‘scaffolding’ to the practice of inquiry into preferred stories” (Carry, Walther, & Russell, 2009, p. 320). White (2007) assumed that people who come to therapy are acting in ways that are known and familiar for them, in their effort to solve their problems, which keeps them with the familiar conclusions about themselves and their relationships. Consequently, people may feel frustrated with their incompetence to problem-solve, and their coming to therapy is likely to be experienced as a verification of their deficiency and inadequacy. Given that White was interested in identity conclusions and alternative more preferred stories, he used “scaffolding” to traverse in conversation from what is known and familiar to what is possible for people to know and do, which he called a “zone of proximal development” (White, 2007). Scaffolding “provides opportunity for people to proceed across this zone in manageable steps” (White, 2007, p. 263). Scaffolding metaphor contributed to White's thinking about,

How we can use therapeutic questions to provide stepping-stones for people to “learn” previously unknown things about themselves in the as yet unexplored territories of their preferred stories. Thoughtfully scaffolded questions can support

people to step from the “known and familiar” of the problem experience into the “not yet known, but possible to know territory of preferred stories. (Carry, Walther, & Russell, 2009, p. 320)

White (2007) believed that in the process of scaffolding it is possible for people to experience:

a newfound sense of personal agency: a sense of being able to regulate one’s own life, to intervene in one’s life to affect its course according to one’s intentions, and to do this in ways that are shaped by one’s knowledge of life and skills of living. (pp. 263-264).

In scaffolding practices, White also takes a de-centered and influential stance because he privileges people’s voices, their intentions, their knowledges, and their skills to move from what is “known and familiar” to what is “possible to know and do,” which creates a sense of personal agency rather than a sense of depending on the therapist and a sense of deficiency.

Vygotsky, who studied early childhood development, emphasized that “development is founded upon learning...and that learning was an achievement not of independent effort, but of social collaboration” (as cited in, White 2007, p. 271). White believed that Vygotsky’s concept of the “zone of proximal development” can be applied to any age and contributes to our understanding of therapeutic change. Vygotsky showed that development of “concepts” of life and identity is the result of meaning development of words.

It is this conceptual development that supplies the foundation for people to regulate their lives: to influence their own actions in purposeful ways, to intervene

in their own lives to shape the course of events, and to problem-solve. According to this understanding, actions that are considered responsible and autonomous have their foundations in social collaboration. The development of this self-regulation is a reflection of what Vygotsky referred to as “self-mastery.” He employed this term in a way that is synonymous with what I have referred to as “personal agency.” (White, 2007, p. 272)

In addition to creating a map for scaffolding conversations, White (2007) believed that, “it is social collaboration in the development of meaning that is essential to the attainment of personal agency and responsible action” (p. 280). White believed that it is therapist’s responsibility to create a context for development of personal agency, to scaffold the proximal zone of development, and to avoid thinking about and labeling people as “resistant,” “incapable,” “irresponsible,” and so forth if they, for example, don’t know the answer to our question. Instead, White (2007) suggested that the therapist can “drop down a level” of his or her inquiry and reflect on his or her skills in order to recognize the limitations of his or her skills and to find new ways of expanding these limits.

### **Derrida**

In addition to Brunner, White was also influenced by a literary theorist Jacques Derrida, who saw “language as a system of differences” or binaries (Gergen, 2009, p. 19). What this means is that a word meaning depends on differentiating that word from what it is not. According to Derrida,

Word meaning depends on differentiating between a presence (the word you have used) and an absence (those to which it is contrasted). To make sense in language

is to speak in terms of presences, what is designated, against a backdrop of absences...the presences are privileged; they are brought into focus by the words themselves; the absences are only there by implication...these presences would not make sense without the absences. Without the binary distinction they would mean nothing. (as cited in, Gergen 2009, p. 19)

Referring to the work of Derrida, White said that, “It’s not possible to talk about anything without drawing out what it is not. Every expression of life is in relation to something else” (Carey, Walther, & Russell, 2009, p. 319). Influenced by Derrida’s deconstructionist arguments, White developed the concept of the “absent but implicit,” and “double listening.” Applying Derrida’s ideas to his work, White proposed that,

In order to make sense of certain experiences, we need to distinguish these experiences from others that already have meaning to us and which have already been described or categorized in some way. In other words, we can only make sense of what things are by contrasting them to what they are not: we can only distinguish isolation if we already have an understanding of connection; and we can only distinguish despair if we already have some knowledge about hope. (Carey et al., 2009, p. 321)

This suggests that therapists can listen not only for what the person describes as a problem, but also, what the problem is not, or what is the “absent but implicit” in their description. “Every expression that a person gives to their experience is in relation to other experiences that are not being named, or that are not evident but are there by implication” (Carey et al., 2009, p. 321). Therapists can listen and explore with a person,

for example, what their frustration speaks about what is important to them, what they value, what they believe in, or what they hold precious that is being violated.

Such an inquiry, about what is in the background of this person's experience that will make sense of the distress that is being expressed in the foreground, offers an entry point to preferred or subjugated stories. From this point, we can go on to develop a rich account of their values, hopes, and commitments and so on that have been transgressed. (Carey et al., 2009, p. 321)

Therefore, listening for the "absent but implicit" can open space for a development of alternative stories and preferred identity conclusions, in which narrative therapists also take a de-centered position by privileging person's voices, meaning, and preferences.

Narrative therapists are not listening for pathology behind what is being said. They are listening for person's hopes, dreams, values, aspirations, commitments, intentions, and so on. They listen for what is being violated in their experiences and what they would prefer instead. They see expressed frustration, pain, sadness, and anger, as people's taking action against what is not okay for them, rather than as a sign of their resistance and psychopathology.

According to White (2003), "Listening can never be considered a neutral activity" (p. 33). White (2003) believed that it is therapist responsibility to establish a listening context in which "expressions of pain and distress are heard and acknowledged, but not in a way that contributes further to these thin conclusions about people's identities, or about the identity of their family or their community" (p. 33). In addition to listening for what is "absent but implicit," White (2003) suggested that team members "attend closely to the transformation of signs and meaning" (p.33) as the conversations evolve, that are

associated with discourses of personal agency rather than discourse of deficit and incompetence.

Drawing from the work of another French philosopher, Gilles Deleuze, Michael proposed that if “difference” is the baseline of experience, then our ears can be drawn to the ever-presentness of stories that are different from the problem story. Everything that is not the problem story becomes a possible site for the emergence of new meanings that can be ascribed more useful and more “agentive” purpose. (Carey et al., 2009, p. 322)

### **Myerhoff**

Even though early on White and Epston saw the benefit of engaging audiences in rich story development, in their contributing to endurance and extension of preferred developments in people’s lives, White’s (2007) understanding of the significance of the audiences was supported by the work of cultural anthropologist Barbara Myerhoff. Myerhoff (1982) worked with elderly Jews, the Holocaust survivors, who were isolated and invisible in their communities and who lost the sense of existence, to help them become visible and to participate in construction of their and other people’s identities through their performances, which Myerhoff calls, “definitional ceremonies.” These performances of life stories, telling and retelling, in definitional ceremonies, are understood “to be collective self-definitions specifically intended to proclaim an interpretation to an audience not otherwise available” (Myerhoff, 1982, p. 234). Sessions were designed as performances in which “people displayed the qualities they wanted seen as much as they could and became what they displayed” (Myerhoff, 1982, p. 244). Myerhoff stated that, “Performance is not merely a vehicle for being seen. Self-definition

is attained through it, and this is tantamount to being what one claims to be” (p. 235). In these “collective self-definitions,” audience played a significant role. According to Myerhoff,

It was the audience response to the stories told and performed in these forums that was verifying of these stories. It was the audience’s acknowledgment of the identity claims expressed in these stories that was authenticating of these identity claims. It was the audience recognition of these stories that so significantly contributed to the community member’s achieving a sense of feeling at one with their claims about their lives. (as cited in, White, 2007)

Myerhoff saw that it was audience’s retelling of person’s story that played the significant role in community members “a sense of being at one with their claims about their lives” and “in renewal of one’s sense of personal authenticity” (White, 2007, p. 184). In summarizing Myerhoff work, White (2007) suggested that the actions of the audience (or community members) reflected the extent to which,

Identity is a public and social achievement shaped by historical and cultural forces rather than by the forces of human nature, however this human nature might be conceived of the outcome of deriving a sense of authenticity through social processes that acknowledge one’s preferred claims about one’s identity and history. (p. 182)

Drawing from Myerhoff definitional ceremonies, White (2007) developed a map for definitional ceremonies that “provides a context for rich story development” (p. 165). In “definitional ceremony,” which includes telling, retelling, and retelling of retelling, the therapist is responsible for preparing the outsider witnesses and for structuring re-telling

conversation. Therapist is taking a de-center position in that he or she is not reproducing dominant discourses by instructing the outsider witnesses to give compliments, affirmations, advices, or to challenge clients or make any other judgments. Rather, outsider witnesses are asked in retelling to speak about their own experience: what they were drawn to, what images came to their mind while listening, why they were drawn to these expressions, and where this conversation may take them (White, 2007).

Myerhoff also influenced White in development of re-membering conversations. Myerhoff (1982) pointed out that, “Memory may offer the opportunity not merely to recall the past but to relive it” (p. 238). Myerhoff (1982) said that,

To signify this special type of recollection, the term *re-membering* may be used, calling attention to the reaggregation of members, the figures who belong to one’s life story, one’s own prior selves, as well as significant others who are part of the story. Re-membering, then, is a purposive, significant unification, quite different from the passive, continuous fragmentary flickerings of images and feelings that accompany other activities in the normal flow of consciousness. (p. 240)

White (2007) stated that, “Re-membering conversations provide an opportunity for people to engage in a revisions of the membership of their associations of life, affording an opening for the reconstruction of their identity” (p. 136). More specifically, re-membering conversations “contribute to the development of a multivoiced sense of identity,” open possibility for upgrading certain voices and some memberships and for downgrading others, “richly describe the preferred versions of identity,” “provide for a two way understanding of person’s relationship with the significant figures in their lives,” and “encourage not passive recollection of one’s past” (White, 2007, pp. 138-139).



Myerhoff stated that, “It is through re-membering that life is given a shape that extends back in the past and forward into the future” (as cited in White, 2007, p. 137). “Without re-membering we lose our histories and our selves.” (Myerhoff, 1982, p. 240)

Re-membering conversations imply and acknowledge that our identity conclusions are relational; they are shaped by important figures in our past and present and they can be re-negotiated which also can contribute to the sense of personal agency rather than to confirmation of the belief that we are stuck with our “encapsulated self.” Re-membering conversations also increase our awareness of our participation in other people’s lives, which can open space for preferred identity conclusion, for rich story development, and for sense of personal agency. Although these conversations are structured, therapist is taking a de-centered and influential position.

In conclusion, many thinkers outside of the mental health field contributed to shaping of White’s ideas and narrative practices. These practices include but not limit to: externalizing conversations, re-authoring conversations, re-membering conversations, definitional ceremonies, scaffolding conversations, and conversations that highlight unique outcomes (White, 2007). Narrative therapy is not a set of techniques to be applied to eradicate specific problems. It is “an epistemology, a philosophy, a personal commitment, a politics, an ethics, a practice, a life, and so on” (White, 1995, p. 37). Narrative therapy creates context and opportunity for re-authoring lives, re-inventing identities, discovery, adventure, and personal agency. It also privileges people’s voices, values and beliefs, which enables them to play more active role in shaping their own lives according to their preferences.

If narrative practices are taken up as “techniques” and used in a worldview that does not encourage collaboration, openness, and ongoing examination of the effects of its practices, they can have undesirable effects. It is vital that practices that have become part of the work not be used out of context of the reflective, deconstructionist, nonpathologizing worldview in which they were developed. (Freedman & Combs, 1996, p. 275)

White (2007) emphasized that “maps” are “guiding ideas of some sort in the development of therapeutic conversations” (p. 6). They are not considered “true” and “correct” guide to narrative practice (White, 2007). White (2007) explained his position in the following way, “I do not use them to police my conversations with the people who consult me. Therapeutic conversations are not ordered, and I make no effort to determine my response to people’s expressions ahead of these expressions.” (p. 5)

### **Therapeutic Relationship in Narrative Therapy**

This dissertation is focused on how Michael White creates and maintains a therapeutic alliance with clients using narrative therapy, taking a decentered and influential position. The reason for studying Michael White, rather than some other narrative therapist, is because he invented the idea of decentered but influential. Not much is written about this position and it is usually unclear to many students of narrative therapy what this position means and entails and how it is performed in the session.

In addition, the decision to study Michael White was based on a fact that he was enormously admired, by many professionals in our field, including myself, for his ability to relate differently with people who were diagnosed with mental illness. Freedman and Combs (1996) wrote that they initially fell in love with how White was able to create

relationships with his clients and they saw “how people could transform themselves and their lives in preferred ways within those relationships” (p. 264). Lynn Hoffman (2002) also admired White and described him as, “a tender therapist but a tough theorist” (p. x). Jeff Zimmerman (as cited in White, 2011) liked that Michael was “genuinely curious” about his ideas, which opened new possibilities in his work as a therapist. Cheryl White, Michael’s wife, said that when Michael worked in a state psychiatric hospital, his way of relating to people was different from usual “professional” ways. Instead of seeing and treating people as “patients,” White treated them as equals who could contribute to his life as well (as cited in White, 2011). It can be concluded that White’s unique way of relating to people inspired and influenced other professionals (including myself) to study his ideas and practice narrative therapy.

Because White was able to create profound therapeutic relationships in which people were able to transform their lives in their preferred ways, it is important to study and explore how he was able to do it. Furthermore, given the importance of positive therapeutic alliance on the outcome of therapy (as evident in second part of this literature review), and a lack of research on how narrative therapists create therapeutic alliances, this study will address that gap in the existing research literature. More specifically, the focus of this study is on how Michael White takes a decentered and influential position in his relationship with people who consulted him.

### **The Effects of Taking a Decentered and Influential Position**

What is known about therapeutic interaction in narrative therapy is that White (1995) believed that it is a two-way phenomenon in which both parties (clients and therapists) are mutually influenced and changed. This is consistent with a social

constructionist worldview in which realities (and meaning) are created in relationships and through use of language. White (1995) also acknowledged the power differential in therapeutic relationships, in which therapists have more power, and therefore, are morally and ethically responsible for their actions. However, being aware of the potential negative effects of this power differential in therapeutic relationship, White strived to always create a more egalitarian relationship with his clients. One way he accomplished this was through transparency (White, 1992; White, 1995).

White (1995) challenged the idea that, for therapy to be effective it is important that persons do not know the therapist's intentions. In contrast, White invited people to evaluate their sessions, and he asked them questions about which parts of the interview were relevant to them and which were not, what was helpful or not helpful for them, and he even encouraged them to interview him about his questions and his intentions behind them (White, 1993). Asking his clients for their feedback on their experience of therapy and giving them opportunity to decide for themselves what they preferred and what they wanted to talk about was important to Michael White in his interactions with people who consulted him (White, 1993; White, 1995; White, 2007).

White also created more egalitarian and collaborative relationships by viewing his clients in a non-pathologizing ways. This is evident in his beliefs that problems do not represent the "truth" about people's identities, in inviting people to objectify their problems rather than themselves as defective, in his refusal to use professional language such as "patients" or "clients," but instead, he referred to them as "people who come to consult me," in his genuine curiosity about their problems, in taking a de-centered position on people's lives by inviting people to evaluate their problems and create their

own preferred identities, in privileging clients' language, skills, and knowledges, in focusing on meaning rather than on facts, in not imposing of his values, beliefs, meanings, etc., and so on (White, 2007; Freedman & Combs, 1996).

In addition to a nonpathologizing view of people, White (1993) expressed his commitment "to action against the abuses of power: against neglect, against cruelty, against injustice, and against the subjugation of the alternative knowledges" (p. 132). These were his values in addition to "solidarity," which White (1993) explained as:

Constructed by therapists who refuse to draw a sharp distinction between their lives and the lives of others, who refuse to marginalize those persons who seek help, by therapists who are constantly confronting the fact that if faced with the circumstances such that provide the context of troubles of others, they just might not be doing nearly as well themselves. (p. 132)

In this statement, it is implied that White was creating egalitarian relationships with his clients; he was interacting with them in the most humane and compassionate way; and he understood that their problems are related to their circumstances. It can be also concluded that his intention was not to put himself above his clients in terms of having a superior knowledge on how to deal with or solve clients' problems. White (1995) did not specify how people should live their lives and he did not prescribe a direction for clients' lives.

### **Decentered and Influential Position of the Therapist**

The position of the therapist in narrative therapeutic relationship is described as a decentered and influential (White, 2007). A decentered stance is briefly described by White (2007) as a position in which "therapist is not the author of people's positions of

the problems and predicaments of their lives” (p. 39). Instead, the therapist creates opportunities for clients to reflect on their experiences and to take their own stance in relation to their problems. Therefore, the client’s voices, knowledges, and preferences are privileged over the therapist’s expert knowledge. In a decentered position, the therapists is not privileged in attributing meaning to clients’ problems; the therapist is not imposing his or her understanding about the consequences of the problems; the therapist does not assume to know what is important to clients; and the therapist does not prescribe directions for how people should live their lives (White, 2007). In other words, the therapist is not reproducing a dominant discourse, is not oppressive, and does not act as an expert who treats defective internal structures. White (2007) described what decentered therapists do not do by saying what centered therapists do. For example,

I can see that this *(problem as defined by the therapist)* is having these *(consequences as drawn out by the therapist)* in your life. This is a *(position authored by therapist)*, and we will have to do something about this because *(justification founded upon therapist’s normative ideas about life)*. (p. 40)

It seems that when the therapist takes a decentered position in relationship with his or her client, that relationship is characterized by collaboration, curiosity, not-knowing, and opening space for new identity conclusions, rich story development, and personal agency.

A decentered position of the therapist also reflects a post-modern, post-structuralist, non-normative, and social construction worldview, as well as, Foucault’s influence on White not to reproduce dominant discourses, not to marginalize people’s knowledges and voices, and to acknowledge the power differential in relationships. Therefore, it reflects striving for and creating more egalitarian relationships. A

decentered position can also be described as one in which therapists adopt a non-pathologizing view of people, in which they refuse to objectify people by prescribing them internal structures as an evidence of their “dysfunctional” or culturally inappropriate or undesirable behavior. Rather, therapists taking a decentered position are aware of and understand that identity conclusions are created relationally through language, therefore, they are not fixed inside the person. A decentered position opens space for new discoveries, new understandings of self and relationships, and new meanings that can lead to taking different directions in person’s life. A decentered stance of the therapist creates a context in which individuals can experience themselves differently in relation to their problem, in their relationships, or/and in their own sense of self. By taking a decentered stance, therapists can also contribute to creating a relationship and therapeutic conversation in which people feel liberated, more hopeful, and more empowered, with a greater sense of personal agency.

A decentered position can also be understood as a position in which the therapist tries to level the hierarchy with clients by collaborating, by asking for their feedback, and by being transparent. It also implies that voices that are silenced by dominant discourses or oppressive stories that people bring in deserve attention and exploration. By taking a decentered position, the therapist is refusing to act as a social engineer. It seems that in a decentered position of the therapist, a political aspect of narrative therapy is clearly evident. White (1995) did not deny that a “therapy is inevitably a political activity” (p. 38), and that you cannot not take a position. However, White’s political stance was to privilege people’s values, beliefs, and preferences, rather than to impose his own values or the values of our Western individualistic culture that prescribes what it means to be a

“real person,” or a “person of moral worth,” according to which people tend to evaluate their lives.

By taking a decentered position, the therapist can provide “people with opportunity to give voice to intentions of their lives and to develop a stronger familiarity with what they accord value to in life” (White, 2007, p. 220) which is evident in conversation that highlight unique outcomes. White (2007) believed that if therapists take authorship over people’s lives, they are likely to experience burden, exhaustion, and burnout as well as to leave people feeling impotent. On the other hand, taking a decentered position may protect therapists from this burden and eventually extend their career.

### **Influential Position**

An influential position of the therapist is described as the therapist’s participation in selecting and bringing forward thin events that are not included in the dominant story so that more preferred stories can be developed (White, 2007). While there are many ways in which therapists can be influential, narrative therapists are influential in a sense that they open many possibilities for people to pursue what they value and hold precious. Thus, the therapist is influential by being intentional and by using questions or categories of inquiry as evident in different maps. For example, in externalizing practice, “the therapist provides people with an opportunity to define their own position in relation to their problems and to give voice to what underpins this position” (White, 2007, p. 39). The therapist is influential by assisting persons (who report negative conclusions about their identity and/or their relationship) to redefine their relationship with their problem and to re-experience their identities through four categories of inquiry: 1) negotiating a



particular experience-near definition of the problem, 2) mapping the effects of the problem, 3) evaluating the effects of the problem's activities, and 4) justifying the evaluation (White, 2007). Through these inquiries the therapist is influential in the sense that he or she conversationally opens many possibilities for people to reflect and evaluate their lives in a different way and to pursue what they value and hold precious.

Externalizing conversation practice is only one example and one map of narrative practice among other maps (e.g., conversations that highlight unique outcomes, re-authoring conversations, re-membering conversations) through which narrative therapists can be seen as being influential. It is not simply about following the maps, which are only guidelines and not set in stone prescriptions for practicing narrative therapy, that make the therapist be influential in narrative therapy. Rather, it is more about whether the therapist helps people explore some neglected territories of their lives and provides opportunities for people to more richly describe the alternative stories of their lives.

In addition, in scaffolding conversations the therapist is influential by assisting a person to progressively traverse from what is known and familiar toward what might be possible for him or her to know and do about his or her identity and life (White, 2007). Drawing from Vygotsky's work, White (2007) emphasized that the learning (or change) is achieved through taking manageable steps and is the outcome of social collaboration that occurs through language. Therefore, the therapist plays a significant role in influencing each conversation through the language he or she uses; for example, the therapist's questions, that are small enough for a person to answer and reflect on, may assist the person to move to a new unexplored and neglected territories that may lead to development of preferred identity conclusions. The therapist's talk may lead to either

learning something new about one's life, identity, beliefs, values, hopes, intentions, skills, relationships, and problem (that often makes a difference in person's life) or it may lead to what the person already knows (familiar conversation) that usually makes no difference in what the person concludes about his or her identity, his or her relationships, and his or her problem. As White (2005) stated:

The therapist is influential not in the sense of imposing an agenda or in the sense of delivering interventions, but in the sense of building a scaffold, through questions and reflections, that makes it possible for people to: a) more richly describe the alternative stories of their lives, b) step into and to explore some of the neglected territories of their lives, and to c) become more significantly acquainted with the knowledges and skills of their lives that are relevant to addressing the concerns, predicaments and problems that are at hand. (p. 9)

Therefore, the influential position of the therapist can be explained as the therapist's skill to be very intentional in his or her inquiry that focuses on assisting individuals to create alternative stories and more preferred identity conclusions without imposing his or her values and beliefs about how they should live their lives and without providing his or her expert insight and interventions.

Narrative therapists use their influential position to explore people's hopes, dreams, goals, aspirations, values, beliefs, skills, and knowledges; rather than to explore, diagnose, and cure their deficiencies (White, 2007), which is the practice in other more normative models and which leads to creating a different kind of relationships between the therapist and the client. These therapeutic relationships can be described and experienced as more egalitarian, respectful, and empowering, instead of more oppressive,

hierarchical, and limiting that could create negative consequences for both the therapist and the client. These consequences include but are not limited to the therapist's burn out and frustration when the client is not compliant with his or her interventions that make sense according to his or her theory; the possible lack of collaboration due to clients' so called "resistance" as perceived by therapist; the client's dependency on the therapist's expert knowledge about how to solve their problems; the client's feelings of incompetence, deficiency, or not being understood when he or she is diagnosed or told what to do that does not fit with his or her values and beliefs, to name just a few.

On the other hand, the relationship in which the therapist is influential but de-centered tends to create a sense of personal agency, competency, and hope. For instance, individuals suffering from anorexia and bulimia reported experiencing sense of relief, freedom, control, and hope as a result of experiencing and being in externalizing conversations (Maisel et al., 2004) in which the therapist takes a de-centered and influential position.

An influential position of the therapist can be evident in therapist's participation in co-creation of new meanings, new stories, and new identity conclusions that are according to clients' preferences and values. Although the therapist is not taking a primary role in authorship of alternative stories, he or she participates in the process and is responsible for the outcome (White, 2007). Narrative therapists are aware of their influential position in relationship with their clients and they examine and question the effects of their practices (Freedman & Combs, 1996; White, 1995).

Influenced greatly by Foucault, White (2002) was aware that a therapist (person in power with expert knowledge) can replicate the dominant discourses and can further

recruit people into disciplining themselves and others based on socially constructed norms, as well as, that therapists could through their authority operate as agents of social control. White refused to be influential in such manner. Instead, White used influential position to provide people “with an opportunity to refuse normative criteria in the judgment and the justification of their activities...[and to]...focus on the consequences of one’s activities in the shaping of one’s life and relationships” (White, 2002, p. 68). Thus, White did not relinquish people from taking responsibility for their actions neither did he blame them for not acting in particular ways that are culturally constructed to be normal; rather, he was able to open space for people to deconstruct problems and to create a different relationships with their problems in which they felt less oppressed by them, were able to hear more their voices and be more empowered to take different actions and responsibility according to their values and preferences. Hence, White was influential in very different way than other therapists who had ideas and norms for clients what it takes to be a normal or functional person or/and family - replicating dominant discourses that are oppressive and lead to self-surveillance, negative judgments, and self-blame given that the people are objectified rather than their problems.

More than any other theorist of his time, White was concerned about the effects of therapeutic practice on people’s lives. By quoting Foucault, “We know what we think; we think we know what we do; but do we know what we do does?” David Epston suggested that White looked at not only intentions but also the effects of therapeutic practice (as cited in White, 2011, p. xxviii). White (2007) believed that therapists are responsible for the consequences of what they think, say, and do in therapy. Given the inherited power differential between the therapist and the client, in which therapists have

more power, White (1995) stressed that it is easy for therapists to impose the “truths” and; therefore, steps should be taken to prevent such imposition.

An influential position, like decentered, reflects White’s worldview, his theoretical ideas, and his acknowledgment of power differential in a relationship, and in a way it holds therapists accountable for the effects of what they do and say in their conversations with people who consult them. White (1995) asserted that, “to enter the belief that therapy can be totally egalitarian, would make it possible for therapists to ignore the special moral and ethical responsibilities associated with their position” (p. 70), which was certainly not his intention. White (2005) also believed that taking a decentered and influential position could be potentially invigorating of therapist.

This study intends to answer the following research question: How, if at all, can Michael White be seen to take a decentered and influential position in narrative therapy? The methodology of this study will be explained in the next chapter.

### **CHAPTER III: METHODOLOGY**

This study used qualitative inquiry, a single instrumental case study design, and conversation analysis as a method of studying the relationship between the therapist and the client. This study aimed to address the following research question: How, if at all, can Michael White be seen to take a decentered and influential position in narrative therapy? This study intended to look for the ways in which White can be seen to take an influential and decentered position in his narrative consultation with the family based on his description of decentered and influential stance. Thus, this study looked at the examples of how White takes a decentered and influential stance in relation to his clients.

#### **Qualitative Inquiry**

Qualitative inquiry, rather than quantitative, was used because this study focuses on exploration of text in context (on qualities) rather than on quantities that require mathematical processes for understanding and interpretation (Strauss & Corbin, 1998). Qualitative inquiry can be used to explore phenomena about which little is known or/and to gain new understanding by obtaining details about the phenomenon (Strauss & Corbin, 1998). In this study, I used qualitative inquiry to explore, describe, and provide detailed understanding of the decentered and influential position of the therapist. Creswell (2007) suggested that qualitative research can be used when “a problem or issue needs to be explored” (p. 39), when “we need a complex, detailed understanding of the issue” (p. 40), and when “quantitative measures and the statistical analyses simply do not fit the problem” (p. 40). We know little about a decentered and influential position of the therapist in narrative therapy and if and how White uses this stance in relationships with his clients. This study did not aim to quantify White’s talk or manipulate any variables,

but rather to focus on how, and if at all, he uses a de-centered and influential stance. In addition, a qualitative inquiry fits with this study research question because it is focused on the processes in observed talk interaction between the therapist and the client rather than on their internal or psychological states that are usually measured and tested in quantitative studies (Hays & Singh, 2012). In contrast to quantitative research methods, qualitative research is more sensitive to context; it “seeks to understand phenomena in context-specific settings” (Golafshani, 2003, p. 600). Hays and Singh (2012) defined qualitative research as “the study of a phenomenon or research topic in context” (Hays & Singh, 2012, p. 4).

Rather than studying a decentered and influential position from a structuralist and positivist worldview that might be used in quantitative studies (Creswell, 2007), a post-structuralist and social-constructionist paradigm was used in analyzing the conversation between the therapist and the client in order to explore if and how Michael White takes a decentered and influential position in relationship with his clients. Finally, a qualitative inquiry was chosen because it can provide thick and detailed descriptions and therefore a deeper understanding of the phenomena being studied (Hays & Singh, 2012) – a decentered and influential position of the therapist - which is the goal of this study.

### **Case Study Design**

A single case study design and conversation analysis were previously used in studies that explored the interactional patterns between the therapist and the client. For example, Gale (1991) studied one-session consultation with solution-oriented therapist, Bill O’Hanlon, to discover the interactional patterns between the therapist and his clients and how the therapist elicits particular responses from clients such as solution-focused

talk. Wickman and Campbell (2003) used a single case study design and conversation analysis to investigate the conversational style of Carl Rogers when he was being “Rogerian” which contributed to a clearer definition of his main concepts: empathy, unconditional positive regard, and genuineness. Thus, using a single case design is a common practice in conversation analysis (Gale, 1996) that requires a microanalysis of talk.

While there are different types of case study designs (Stake, 1995), a single case instrumental design was used in this study, because the intention was to gain the insight and understanding of a decentered and influential position of the therapist in relationship with clients. Instrumental case study designs are used when there is “a need for general understanding, and feel that we may get insight into the question by studying a particular case” (Stake, 1995, p. 3).

In this study, I used a single study instrumental case design because one session was studied intensely in order to provide a great detail about a therapist who takes a decentered and influential position, given that there is lack of research on this topic. Also, the intention of this study was to understand the concept rather than to generalize it through measurement and testing hypothesis, which is more consistent with quantitative research methods. As Stake (1995) stated: “The real business of case study is particularization, not generalization. We take a particular case and come to know it well, not primarily as to how it is different from others but what it is, what it does” (p. 8). Once the concept of a decentered and influential position of the therapist is understood and more richly described with examples, future studies can compared it with other available cases and quantitative methods can be used to test future research hypothesis.



Since not much was written and understood about this idea, a single instrumental case study design seemed to be the appropriate first step.

### **Conversation Analysis**

Conversation analysis originated from ethnomethodology in 1960s (Gale, 1996). Ethnomethodology, a style of social research, investigates “the ways in which collectivity members create and maintain a sense of order and intelligibility in social life” (ten Have, 2007, p. 139). Harold Garfinkel, a sociologist, who developed ethnomethodology, was interested in studying how people analyze, make sense, and perform social activities using ethno methods of reasoning (Gale, 1996). As reviewed by Gale, Garfinkel believed that people’s actions are social accomplishment and he saw language as a “reality-constituting practice,” rather than representation of reality, which is similar to the social constructionist view of reality.

While most qualitative researchers are interested in knowing “the world as participants see it, ethnomethodologists prefer to study how, by the use of which procedures and methods, any particular ‘world’ is produced and perceived” (ten Have, 2007, p. 139). Instead of conducting interviews, ethnomethodologists tend to study and analyze naturally occurring talk, which often includes audio and video recordings (ten Have, 2007). Given that the focus is on how participants use language in interaction, as Gale (1996) stated, “analyzing interviews as they occur in various settings (e.g., a clinical encounter) is a useful ethnomethodological activity for understanding how the participants construct a social institution (e.g., therapy)” (p. 109).

What ethnomethodology and conversation analysis have in common is their preference for studying naturally occurring talk rather than conducting experiments, they

both focus on “how participants themselves produce and interpret each other’s actions,” and “the researcher treats all the interactional empirical data as unique and different and thus worthy of serious analytic attention” (Pomerantz & Atkinson, 1984, as cited in Gale, 1991, p. 29).

Conversation analysis (CA) was founded by Harvey Sacks and his colleagues, Jefferson and Schegloff, who developed methods for studying naturally occurring talk (Gale, 1996). Hutchby and Wooffitt (2008) defined conversation analysis as “the study of recorded, naturally occurring talk-in-interaction” (p. 12) that focuses on how participants in their conversation orient each other, organize, and interpret their talk. In other words, how their talk is organized “from the perspective of how participants display for one another their understanding of ‘what is going on’” (Hutchby & Wooffitt, 2008, p. 13). Thus, by analyzing the therapist and the client talk, it could be observed how they interpret and understand their utterances. However, in this study the main focus was on examining the therapist’s talk and how and, if at all, he took a decentered and influential position in his interaction with clients. This study did not look at the relational effects of White’s decentered and influential position, but rather examples of that position and ways in which he used it, if at all.

Use of recordings in conversation analysis provides the researcher opportunity to make precise and detailed observations of interactional patterns that could be lost in experimental methodologies (Heritage, 1984). In addition, “It permits other researchers to have direct access to the data about which claims are being made, thus making analysis subject to detailed public scrutiny and helping to minimize the influence of personal preconceptions or analytical biases” (Heritage, 1984, p. 238).

Gale (1996) suggested that CA as a method has many advantages for practitioners because it can bridge research and practice in many ways. These include: studying how therapists achieve success, studying if they do what they say they do, demonstrating how social identities are created in interaction and through language, using it as a method for self-supervision, and so forth (Gale, 1996). According to Gale (1996), “CA can examine how clinicians actually perform a particular therapeutic model” (p. 120). Heritage (1984) stated that conversational analysis has no fixed intrinsic agenda in terms of which objectives could be studied. “Rather, conversation analysis represents a general approach to the analysis of social action which can be applied to an extremely varied array of topics and problems” (Heritage, 1984, p. 291). The advantage of conversation analysis is that it is “nondisruptive to the conversations that it explores” (Gale, 1991, p. 23). Even though the investigator is the instrument of the inquiry, he or she does not influence the development of recorded conversation unless he or she has conducted the interview or/and has been present.

“CA has developed through empirical studies that have focused on specific, observable phenomena. So, in the first place, CA is not a theoretical, but very concretely empirical enterprise” (Perakyla, 2007, p. 154). Sacks initially studied phone calls in suicide prevention facility and the problem of getting the callers name (Hutchby & Wooffitt, 2008). Sacks’s original idea was that, contrary to the belief that conversations are random, “there is ‘order at all points’ in talk-interaction” (Hutchby & Wooffitt, 2008, p. 19). According to Hutchby and Wooffitt, “For CA, the notion of order at all points means that nothing in talk-in-interaction should be dismissed as trivial or uninteresting

before we have subjected it to analysis” (p. 20). Thus, the researcher approaches data with an open mind and without priory knowledge which details are important.

While in quantitative research hypotheses are first made and then tested in a controlled and systematic investigation, in conversation analysis “observations are used as the basis for theorizing” (Gale, 1991, p. 28). For example, Gale and Newfield (1992) studied how the therapist, O’Hanlon, used language to achieve his therapeutic agenda in marital therapy session. These researchers developed and described nine categories of O’Hanlon’s procedures (e.g., pursuing a response over many turns, using humor to change topic, clarifying unclear references, overlapping talk in order to get a turn, reformulation of meaning, offering a candidate answer) for pursuing a solution oriented talk. Wickman and Campbell (2003) used conversation analysis to examine Carl Rogers’s conversational style; how he enacts his main ideas of empathy, genuineness, and unconditional positive regard. According to their analysis, Rogers uses meta-statements to promote genuineness, he externalizes internal dialogue to communicate empathy, and he withholds giving advice to demonstrate unconditional positive regard (Wickman & Campbell, 2003). Hence, conversation analysis is an inductive rather than deductive methodology that is “rigorously empirical...[and]... avoids premature theory construction” (Levinson, as cited in Gale, 1991, p. 28) that can be used to investigate the position of the therapist in narrative therapy. Even though, some effects of taking a decentered and influential position were described, more can be learned about how, if at all, White uses a decentered and influential position in narrative therapy. This study looked at the ways in which White can be seen to take this position based on what he said.

## Assumptions

According to Heritage (1984), three fundamental assumptions of conversation analysis are: “(1) interaction is structurally organized; (2) contributions to interaction are contextually oriented; and (3) these two properties inhere in the details of interaction so that no order of detail can be dismissed, *a priori*, as disorderly, accidental or irrelevant” (Heritage, 1984, p. 241). Gale (1996) expanded these points by saying that,

Conversations are meticulously co-orchestrated phenomena. An individual’s action is not independent of the actions of others but is patterned in relationship to other’s actions. Meanings are expressed and understood precisely because there are patterned structures to interactions. Second, simultaneously as speakers shape their utterances specifically for intended recipient(s), their utterances also contribute to the continuation or closing of that context. Thus, every action both shapes the context and is constrained by the context. Third, CA examines paralinguistic (and sometimes the nonverbal) features of talk as well as the structural sequencing of the various turn takings. Therefore, all interactional features of the context are relevant to the analyst. (p. 109)

It seems that main assumption of conversation analysis, as explained by Gale, is that understanding is achieved in circular fashion and that individual actions cannot be understood in isolation. The focus is not on internal structures of individuals involved in interaction, but instead on how their actions accomplish particular meanings (Gale, 1996). Thus, “The analysis is sensitive to pattern and form, rather than focusing on substance” (Gale, 1991, p. 32). Given that conversation analysis investigates social interaction, it was possible to obtain new insights and understanding of relational

dynamics between the therapist and the client through application of this methodology (Perakyla, Antaki, Vehvilainen, & Leudar, 2008). By studying moment-by-moment talk between the therapist and the client, it was possible to describe in great detail how the therapist and the client interact and how the therapist takes a decentered and influential position.

Conversational analysts use exemplars from transcript to support their observations, such as categories of patterns (Gale, 1991). According to Gale (1996), the conversation analysis method is similar to the Taylor and Bogdan's analytical induction and Glaser and Strauss's constant comparative method. Some of the micro patterns studied in previous research are turn-taking switches, adjacency pairs, accounts, preliminaries (Gale, 1996), overlapping talk, repair (Hutchby & Wooffitt, 2008), and so forth. Hutchby and Wooffitt (2008) suggested that researchers often use different techniques in conversation analysis and that specific techniques may work well for one researcher but not for another. They suggested approaching data with "conversation analytic mentality" which is described as "sitting down with a transcript, and the associated tape, and trying to describe, turn by turn, what is going on in the talk." The conversation analytic mentality is also described by "approaching data in terms of 'What are the participants doing here?', 'How they are accomplishing that?', and 'How do they display the orderliness of the talk for each other?'" (Hutchby & Wooffitt, 2008, p. 133). These questions guided the researcher in approaching data to answer her research question.

I used qualitative inquiry, a single instrumental case study design, and conversation analysis because they methodologically fit with my research question. The

purpose of this study was to explore and describe if and how White interacts with his clients taking a decentered and influential position, an idea invented by White that was not previously studied and richly described. Qualitative case study was used because the focus of this study is to richly describe and understand a decentered and influential position, and conversation analysis was used to accomplish that goal. Conversation analysis is a qualitative research method used to analyze “segments of therapeutic encounters” (Gale, 1996, p. 111) or entire session of a single case and is “concerned with process (the “how” question)” (p. 111). It is a microanalysis of naturally occurring talk that can be used to understand and describe how participants (the therapist and the client) construct their relationship through language (Gale, 1996). The focus of this study was on process and how and if at all White takes a decentered and influential position in relationship with clients. Examples of how this stance can be used will be provided in Chapter 4. Hence, the proposed methodology seemed appropriate for accomplishing the goal of this study.

## **Procedure**

### **Selecting Data**

In conversation analysis, instead of transcripts, video or audio recordings of naturally occurring interactions are considered ‘the data’ (Hutchby & Wooffitt, 1998). A single session by Michael White was chosen for several reasons. First, Michel White is one of the inventors of narrative therapy and his ideas are dominant in this approach. He was highly respected by his colleagues in mental health field for his innovative ideas and his ability to create positive relationships with his clients. White invented the idea of decentered and influential. Secondly, the single session case that was used is seen as

representative of Michael White's work and his decentered and influential position.

Third, the single session case that was used is a commercially available video recorded session, which allowed the researcher to examine the context of therapy and influential but decentered stance in great detail. I followed these inclusion criteria in selecting a case for analysis.

Several strategies were used to identify video sessions of Michael White. I searched family therapy databases for Nova Southeastern University patrons via official library website; more specifically, I searched Counseling and Therapy in Video: Volume I, II, and III database section and Nova Catalog for any DVDs located in Alvin Sherman Library at NSU. I identified three video session interviews by Michael White called, "Re-authoring Lives in the Face of Lost Dreams," "The Best of Friends," and "Re-authoring Relationships through Stories of Caring." All three video sessions are commercially available at the [www.masterswork.com](http://www.masterswork.com) website. I have contacted a representative at the Master's Production and was assured that I can use the White's video sessions for my research project (J. Andrews, personal communication, February 9<sup>th</sup>, 2016). I chose to use White's session called, "Re-authoring Lives in the Face of Lost Dreams," because it is a full session, does not have many interruptions and comments as in other sessions, and it fits the inclusion criteria of this study. Before transcribing the video session and analyzing the data, this study was submitted for an Institutional Review Board (IRB) review at Nova Southeastern University and was officially approved.

### **Transcribing**

Given that transcribing is a discovery process as well as constructive activity, it is important in conversation analysis that the researcher herself or himself transcribes the



video session (Gale, 1991; 1996). Therefore, I transcribed White's video session using my headphones in my home office. The video session was transcribed into a Word document that was saved into my password-protected computer to which only I have access. I repeatedly listened to and watched video session in order to refine the transcript. The session was first transcribed verbatim and then the notation system (see Appendix B) that fits conversation analysis conventions was used for transcribing and conversation analysis of the session. Furthermore, I collaboratively listened to the video session with my dissertation chair in order to further improve the transcript.

### **Data Analysis Steps**

In this study, the conversation between White and his clients was transcribed in as much details as possible in order to gain insight and describe how White uses a decentered and influential position in relationship with his clients. I transcribed the video session using transcription conventions as described in Appendix B. Using inclusion criteria (see Appendix A), which I have created based on review of White's literature, I examined the research question: How, if at all, can Michael White be seen to take a decentered and influential position in narrative therapy? These inclusion criteria in Appendix A are only some, but not all, of the kind of things that I was looking as I analyzed the qualities of White's talk. I was open to discover examples of decentered and influential position that I did not find in White's writings but which I observed in the video session (see Chapter 4 for more details) in addition to describing ways in which he can be seen to take this stance based on what he said. Also, I was alert to distinctions between an influential position, a decentered position and a combination of both. The

exclusion criteria were times when White did not take a decentered and influential position. These few examples were noted but were not further analyzed.

The findings of this study contributed to richer description of ways in which a decentered and influential position can be used in narrative therapy, since the phenomenon of investigation (decentered and influential stance) is better understood and more richly described. Those descriptions can also be a useful tool for future studies in which researchers are interested in studying a relationship between the decentered and influential position of the therapist and other factors as well for educational and training purposes in supervision and self-supervision.

After initial transcribing, it appeared that White can be seen to use decentered and influential stance based on inclusion criteria. I proceeded by identifying and analyzing instances in conversation so that I can describe in more details ways in which Michael White takes a decentered and influential position in narrative therapy. I immersed myself in a continuous recursion process of listening and watching video session, transcribing and refining the transcript, “developing categories of patterns, and comparing these categories with subsequent segments of talk” (Gale, 1996, p. 112). Coding of transcript to categorize data was done using track changes in review section and tools on Microsoft office Word document.

I used, as suggested by Gale and Newfield (1992), the constant comparative method which involves “simultaneously coding and analyzing the data in order to develop concepts,” and analytic induction that involves:

- a) developing a hypothesis (or category); b) studying the fit of the phenomenon with the hypothesis; c) reformulating the hypothesis if it does not provide a good

description; d) looking for negative cases to disapprove the hypothesis; and e) when negative cases are found, reformulating the hypothesis or redefining the phenomenon. (p. 157)

Thus, upon initial analyzing, various categories were considered and studied for fit with my hypotheses (Appendix A). I constantly compared descriptions (categories) with the text. The exemplars in text helped decide whether or not Michael can be seen to demonstrate an influential and decentered stance with the clients. Emerging themes and supra-themes were modified, if needed, based on relevant examples (or negative examples) in text. Finally, I present my findings of if and how White takes a decentered and influential position, through the use of exemplars from the transcript to support my observations (see chapter IV). Direct quotes from the transcript will help reader decide about the validity of my observation, analysis, and claim about descriptive specification of a phenomenon- decentered and influential position of the therapist.

### **Quality Control**

In order to establish quality control, Gale (1996) stressed several ways that credibility, applicability, and dependability can be maximized in conversation-analytic research, which I used. According to Gale, credibility is achieved by “soaking” oneself in the data; that involves repeated listening, watching, and refining transcript, then by sharing transcript with co-researchers and discussing observed patterns and emerging themes, by using deviant examples to refine category development, by supporting particular patterns and themes with showing evidence of repeated examples, and by writing a journal. Dependability and applicability of the study is maximized by providing the entire transcript to readers for their review and conclusions, as well as, by describing

procedures used by the researcher in conducting the study (Gale, 1996). These recommended strategies were employed to ensure the trustworthiness of this research study.

In addition, I approached data analysis with an open mind and curiosity, rather than confirmatory and restrictive attitude, in order to investigate the ways in which White takes a decentered and influential position in narrative therapy. Even though this is a “discovery oriented research,” it does not mean that categories are there to be found. Rather, the categories constructed were my descriptions of what I saw as meaningful. In addition, discovery oriented research means that the researcher started the study open-minded, without prior ideas what to expect to “find” in analysis (Gale, 1991). Even though I had some ideas about a decentered and influential position of the therapist based on reading in narrative therapy literature and my inclusion criteria (as described in Appendix A), I did not have a prior knowledge about the details of this stance; in other words, if White accomplishes this stance, and if so, how he does it. Each description and theme developed is a subject to reader for his or her own understanding, analysis, and interpretation of meaning given that each reader will use his or her own world view to make sense of what is presented as finding. In addition, to reduce my biases, I met with my dissertation chair, who practices narrative therapy, and my committee members, who are not narrative therapists, to discuss my observations and to obtain their feedback. Sharing my observations with my committee members, who are not narrative therapists, and asking for their feedback maximized trustworthiness of findings.

## **CHAPTER IV: FINDINGS**

Upon completing the data analysis processes I organized the data according to themes, supra-themes, and sub-themes to describe richly and illustrate how Michel White takes a decentered and influential position in narrative therapy. I discovered that White can be seen to take a decentered and influential stance while practicing narrative therapy based on how he described it in the literature and my inclusion criteria (see Appendix A). However, during the process of conversation analysis additional themes emerged from the data that were not mentioned throughout the literature on decentered and influential position in narrative therapy. I describe those in Part Three: Surprises of this chapter. These themes are additional ways of practicing decentered and influential stance.

During the data analysis process, sub-themes emerged from data for many themes, and that information can contribute to understand better the performance of decentered and influential stance. Supra-themes are created to represent and summarize main themes – how I saw White being decentered and influential.

In first part of this chapter, tables for decentered and influential stance are used to illustrate findings. The tables include supra-themes, themes, and sub-themes in order to describe richly White's decentered and influential position in narrative therapy session.

In Part Two, the examples from the transcript (short segments) are included for each theme to support my observation that White can be seen to practice a decentered and influential position and to more richly describe how he does it with use of direct quotes.

In Part Three: Surprises, the tables and examples are presented for themes that emerged from data analysis that were not included in my literature review and inclusion

criteria. The findings of this study are my interpretation and are presented to readers for their evaluation and interpretation. Therefore, they should not be seen as facts or static.

### Part One: Tables

Table 1

#### *Michael White's Decentered Position*

Supra-Themes	Themes	Sub-Themes
<u>COLLABORATIVE</u> Therapist seems to collaborate with clients by privileging client's voice, interpretations, meanings, skills and knowledges, and preferences, by paying close attention to client's language, and by listening to and asking what is important to client.	Therapist privileges client's voice.	
	Therapist privileges client's interpretations.	
	Therapist privileges client's meanings.	
	Therapist privileges client's skills and knowledges.	
	Therapist privileges client's preferences.	Therapist privileges client's preferences about the content of conversation, setting, and reflecting team.
	Therapist pays close attention to client's language.	
	Therapist seems to listen to what is important to client.	
	Therapist asks what is important to client.	

Table 1 continues

*Michael White's Decentered Position*

Supra-Themes	Themes	Sub-Themes
<u>EGALITARIAN</u> Therapist seems to create egalitarian relationship with clients by being transparent, and by asking for client's feedback. Therapist seems to create egalitarian relationship by inviting clients to evaluate session and provide their feedback. By asking clients to reflect and evaluate their problems, therapist creates egalitarian interaction.	Therapist seems to be transparent.	Therapist seems to be transparent about: a) the setting, b) the process of therapy, c) his experience of session, and d) his intentions.
	Therapist asks for client's feedback.	Therapist asks clients for their feedback about: a) the content of conversation, b) the setting, c) client's experience in the session, and d) the process of conversation.
	Therapist invites clients to evaluate session.	
	Therapist asks client to evaluate problems.	

Table 1 continues

*Michael White's Decentered Position*

Supra-Themes	Themes	Sub-Themes
<u>NON-HIERARCHICAL/ NONEXPERT</u>		
Therapist refrains from taking a hierarchical position. Therapist tries to level hierarchy by respecting clients' meanings and understandings about their problems, by taking a decentered stance about what is the best for them and how they should live their lives, and by not providing his expert knowledge and judgment in terms of compliments, solutions, insight, and normalizing. Ultimately, clients are seen as experts on their lives, not therapists. White believed that there is a hierarchical difference between therapist and client but that there are many ways how therapist can try to level that hierarchy.	Therapist refrains from attributing meaning to client's problems.	
	Therapist avoids imposing his understanding about the consequences of the problems.	
	Therapist does not act as a primary author in how clients should live their lives.	
	Therapist avoids prescribing directions for client.	
	Therapist holds back knowing in advance what is best for the client.	
	Therapist avoids providing solutions for client.	
	Therapist avoids providing compliments.	
	Therapist avoids providing his own insight.	
	Therapist avoids confronting clients about their beliefs.	
	Therapist refrains from providing normalizing judgment.	Therapist avoids providing his own insight by asking questions and privileging client's voice, and by using editorial that includes client's languages, preferences and meanings.



Table 1 continues

*Michael White's Decentered Position*

Supra-Themes	Themes	Sub-Themes
<p><u>NON-PATHOLOGIZING</u> <u>/POST-STRUCTURALIST</u> <u>VIEW</u></p> <p>Therapist refuses to objectify and categorize people and to see them in totalizing ways because he is not seeing them as having internal structures that need to be fixed into becoming less pathological or normal. This position is informed by post-structuralist world-view Therapist refuses to reproduce dominant discourse and avoids simplistic behavioral goals. Therapist sees clients as acting according to their intentions, values, beliefs, plans, hopes, aspirations, goals, and dreams.</p>	<p>Therapist avoids providing diagnosis for client's problems and avoids objectifying the client.</p> <p>Therapist refuses seeing client in totalizing ways.</p> <p>Therapist refrains from seeing clients as having internal structures.</p> <p>Therapist avoids categorizing people.</p> <p>Therapist rejects trying to fix people into becoming normal.</p> <p>Therapist avoids asking questions that verify client deficiency or inadequacy.</p> <p>Therapist avoids seeing problems in totalizing ways.</p> <p>Therapist avoids simplistic behavioral goals.</p> <p>Therapist sees clients as acting according to their intentions, values, beliefs, hopes, dreams, aspirations, and/or goals.</p>	
<p><u>CURIOSITY</u></p> <p>Therapist mostly asks questions, and mostly avoids making statements and giving advice.</p>	<p>Therapist mostly asks questions.</p> <p>Therapist mostly avoids making statements and giving advice.</p>	

Table 2

*Michael White's Influential Position*

Supra-Themes	Themes
<p><u>CO-RESEARCHER AND CO-CREATOR OF CONTEXT FOR RICH STORY DEVELOPMENT/ NARRATIVE METHAPHOR</u></p> <p>Therapist is influential by providing opportunities for clients to deconstruct their dominant story, to more richly describe alternative stories, and to step into and explore some neglected territories of their lives.</p>	<p>Therapist provides opportunities for clients to more richly describe the alternative stories of their lives.</p> <p>Therapist provides opportunities for clients to step into and to explore some of the neglected territories of their lives.</p> <p>Therapist provides opportunities for clients to deconstruct their dominant story.</p>
<p><u>CO-CREATOR OF CONTEXT FOR PREFERRED IDENTITY CONCLUSION / POST-STRUCTURALISM</u></p> <p>Therapist is influential by creating a context in which clients have opportunities for re-experiencing their identity and creating a more preferred identity conclusion. This is based on a post-structuralist view of identity. Therapist is influential by objectifying client's problems and asking questions about client's hopes, dreams, intentions, aspirations, and preferences. Therapist is also influential by assisting clients to move from what is known and familiar to what might be possible for client to know about his/her life and identity. By providing opportunities for client to revise the relationship with the problem, clients may experience their preferred identity.</p>	<p>Therapist provides opportunities for clients to redefine their relationship with the problem and/or to re-experience their identity.</p> <p>Therapist provides opportunities for clients to create a more preferred identity conclusion.</p> <p>Therapist assists clients to move from what is known and familiar to what might be possible for him or her to know about his or her life and identity by asking questions.</p> <p>Therapist asks questions that seem to lead to learning something new or neglected about clients' hopes, dreams, intentions, aspirations, and preferences.</p> <p>Therapist objectifies client's problems.</p>

Table 2 continues

*Michael White's Influential Position*

Supra-Themes	Themes
<p><u>CO-CREATOR OF CONTEXT FOR REFLECTION, DISCOVERY, LEARNING AND PERSONAL AGENCY</u></p> <p>Therapist is influential by providing opportunities for clients to become more significantly acquainted with the knowledges and skills of their lives that are relevant to addressing the concerns, predicaments and problems that are at hand, and by asking questions that open possibilities for clients to pursue what they value and hold precious. Therapist also creates context for reflection, discovery, learning, and personal agency by refraining from imposing his agenda and delivering interventions and by avoiding to ask questions that seem to lead to known knowledge.</p>	<p>Therapist provides opportunities for clients to become more significantly acquainted with the knowledges and skills of their lives that are relevant to addressing the concerns, predicaments and problems that are at hand.</p> <p>Therapist avoids asking questions that seem to lead to known knowledge.</p> <p>Therapist refrains from imposing his or her agenda and delivers interventions.</p> <p>Therapist asks questions to open possibilities for clients to pursue what they value and hold precious.</p>

## **Part Two: Examples from Transcript**

In this section I presented examples from the transcript that correspond to each theme for White's decentered and influential position. That way, readers can quickly move from reading tables and finding supporting evidence in this section. In addition to presenting exemplars for each theme they are annotated with my own interpretations. Readers can also refer to Appendix B in order to understand the notations in the transcript.

The narrative consultation case that I used for this study is entitled "Re-authoring Lives in the Face of Lost Dreams" lasts 105 minutes, including reflecting team. In this session, Michael White (MW) consults with Diane (D), her two young children Mathew (M) and Andrew (A), and her mother Dorothy (Do). Diane is a 38-year-old White Caucasian graduate student of psychology who has been divorced about a year. She worked in area of public health before her children were born. Diane's older son Andrew, who is seven years old, was born with severe disabilities and has a seizure disorder. Diane had many hopes that Andrew would be better. Diane's younger son Mathew is five years old and attends special ED preschool. Diane reported that she was struggling with remaking her life as a single mother with children with disabilities and her crises around meaning. Her mother, Dorothy, who was initially observing the session behind the one-way mirror, also joined the session. The main themes from the session incorporate her changed relationship with hope and reinventing her preferred identity conclusion that involves a sense of self-esteem, refusing to be so disciplined, getting in touch with her creativity and intellectual capabilities, being herself more, being more open with other people, and not being perfect.

## Decentered Position

### Collaborative

White seems to collaborate with clients by privileging client's voice, meanings, interpretations, skills and knowlegdes, and preferences, by listening to and asking for what is important to client, and by paying close attention to client's language. It appears that White collaborates with clients when he is taking a decentered position.

Supra-Themes	Themes	Sub-Themes
<u>COLLABORATIVE</u> Therapist seems to collaborate with clients by privileging client's voice, interpretations, meanings, skills and knowledges, and preferences, by paying close attention to client's language, and by listening to and asking what is important to client.	Therapist privileges client's voice.	
	Therapist privileges client's interpretations.	
	Therapist privileges client's meanings.	
	Therapist privileges client's skills and knowledges.	
	Therapist privileges client's preferences.	Therapist privileges client's preferences about the content of conversation, setting, and reflecting team.
	Therapist pays close attention to client's language.	
	Therapist seems to listen to what is important to client.	
	Therapist asks what is important to client.	

**Therapist privileges client's voice.** In this example, White privileges the client's voice by asking her about her way of thinking about hope rather than assuming or suggesting that hope is a positive thing in her life.

*Example 1*

- 1251 D: That's really (1.6) I didn't think of it in  
 1252 terms of my hoping for myself.
- 1253 MW: Right, was it important to think about like  
 1254 that? Is that a helpful way of thinking about  
 1255 it or? =
- 1256 D: = um (3.0) yeah yeah. >I mean cause I  
 1257 invested so much< time in (.4) hoping that  
 1258 the children will be okay hoping that my  
 1259 marriage would work out hoping that you  
 1260 know everything =
- 1261 MW: = yeah =
- 1262 D: = and having to let go of those hopes is  
 1263 really (.6) important so (.4) I guess it is kind  
 1264 of shifting my relationship to hope =
- 1265 MW: = yeah yeah yeah =

Note: White is decentered by asking her, "Is that a helpful way of thinking about it or?" (lines 1254-1255), which in turn helped the client learn something new and realize how her relationship with hope impacted her life and shifted.

**Therapist privileges client's interpretations.** White is privileging the client's interpretations by using editorial in this example. An editorial is the question posed by the therapist that includes the client's previous comments or interpretations and ends with check-in type of question such as, for example, "is that right?"

*Example 1*

- 1183 MW: = okay so there are two major changes in  
 1184 your relationship with hope. um (.6) One of  
 1185 it, is that it doesn't extend your (inaudible)  
 1186 so much (1.0) and the other one is that  
 1187 you're allocating some of it to yourself, is  
 1188 that right?  
 1189 D: Yeah.

Note: White is privileging the client's interpretations by using editorial, which includes the client's previous interpretations about how her relationship with hope changed and checking-in question "is that right?" A more centered therapist usually would summarize what he or she heard by expressing his or her expert opinion, which is based on therapist's etiology of problems and worldview. I noticed that White did not do that, and that instead, he respected the client's interpretations.

**Therapist privileges client's meanings.** White is privileging client's meanings by being curious and asking open-ended question about the meaning of the client's crises in this example.

*Example 1*

- 592 MW: Okay you mentioned a little bit about (.6)  
 593 how you had this a bit of a crisis around  
 594 meaning, was that? =  
 595 D: = uh-huh =  
 596 MW: = is that correct? Can you tell me a little

597                      about what that crisis is about?

Note: White is taking a decentered position by asking the client, “Can you tell me a little about what that crisis is about?” (lines 596 -597). Note that this open-ended question is not one of the first things that therapist said in this session; instead, it is based on what White heard from the client in their conversation while he was trying to get to know them. White is curious to learn from the client about “that crisis” and therefore, he privileges client’s meanings. I noticed that White did not make statements consisting of his expert knowledge and meanings.

**Therapist privileges clients’ skills and knowledges.** White privileges the client’s skills and knowledges by asking how question. The how question can be seen as a short version of how were you able to do that question.

*Example 1*

1516    MW:    = how?  
 1517    D:       = and just be myself more I mean I feel like  
 1518            I’m (.6) I can I’m expressing who I am so  
 1519            much more than kind of being (.5) tied so  
 1520            much with this other person and wondering  
 1521            whether what I am doing is satisfactory to  
 1522            him and =

Note: In this example, White did not come up with his conclusion by offering statement or assumed that he knew about client’s skills and knowledge, but instead, he asked the “how” question which shows his curiosity and that he privileges the client’s knowledge



and skills. As a result, the client expressed her skills that she is able to be and express more who she is without wondering if that's satisfactory to her husband.

**Therapist privileges clients' preferences.** In this session, White privileges the client's preferences about: a) the content of conversations, b) the setting, and c) the reflecting team.

*Example 1 – about content of conversation*

459 MW: I would be interested to know what would  
 460 you be interested in talking about today,  
 461 because I (.5) you know I don't have much  
 462 information about =  
 463 D: = uh-huh =

*Example 2 – about setting*

473 MW: [can I also say you know I would be  
 474 interested in what conditions would be the  
 475 best for you? Whether you would like  
 476 children to be present or you would prefer  
 477 that [

*Example 3- about reflecting team*

2541 MW: = um \*any\* normally I would ask few more  
 2542 questions about that but (inaudible) and um  
 2543 I think that we should (find this out) fairly  
 2544 soon >any other do you have any other  
 2545 thoughts about reflections?< ((asking

2546 Dorothy))

Note: White privileges client's preferences by asking, "what would you be interested in talking about today" (line 460), "what conditions would be best for you?" (lines 474-475), and "do you have any other thoughts about reflections?" (lines 2544-2545). A more centered therapist might suggest who needs to be present for the session for therapy to work or for the family system to be fixed, he or she might provide a direction for content based on a given diagnosis and look for particular answers such as if the client is taking medications as prescribed by doctor, how often she is depressed, and so on. I noticed that White did not suggest that and instead he respected the client's preferences by asking her these questions above.

**Therapist pays close attention to client's language.** White repeats back that he heard a client using the client's language. He is not reframing the client's words. In this segment, they talked about the client's fear of not being perfect.

*Example 1*

1741 D: [that I am not perfect or

1742 something ((laughs)) =

1743 MW: = okay [a fear of being not perfect

Note: White is decentered by paying close attention to the client's words, and by saying, "okay a fear of being not perfect," he respects the client's interpretations of her experience. He inserted the word "fear" because they were previously talking about her fears and the client mentioned it first in the line 1629 in the transcript. On the other hand, a centered therapist might challenge the client's statements or beliefs by asking the client for the evidence that made her believe that she is not being perfect or would try to

reframe her experience of fear by using different words or constructs (e.g., multigenerational transmission process, differentiation of self, complex of inferiority, being stuck in negative self-talk, lack of self-acceptance) so that the client changes her view of the problem. Since the client is at the center of the interaction not the therapist, the client's language is privileged – given that words have meaning and shape realities.

**Therapist seems to listen to what is important to client.** In this example, White communicates that he is interested in listening to and talking about what is important to the client.

*Example 1*

984 MW: [no no I am not looking for any  
985 particular answer I am interested in what  
986 you are interested in talking about and =

Note: White communicates that the client is privileged in deciding on the content of conversation and ensures the client that there are no right or wrong answers. He is decentered and collaborates by listening what is important to the client.

**Therapist asks what is important for client.** In the first example, White is asking about the client's future plans and her program, which seemed important to the client. In the second example, White is asking the client if the support team is important to her.

*Example 1*

164 MW: = yeah wow is that after how long? How  
165 long is the program been? =  
166 D: Two years =  
167 MW: = Two years \*yeah\*=

- 168 D: yeah.
- 169 MW: And where do you go from there when you
- 170 graduate?

*Example 2*

- 734 D: = we both know that we need each other for
- 735 that (.4) so we really try to work hard >and
- 736 I guess I do feel like I have < a team
- 737 anyway I mean between (.) the therapists and
- 738 Andrew's teachers and my parents and
- 739 (.5) um his doctors >I mean< it really is (.9)
- 740 it's a community ((smiles))
- 741 MW: yeah yeah and that's been important?
- 742 D: It's been essential [yeah

Note: In the first example, White shows that he is interested in what is important to the client by asking about her goals or plans, "And where do you go from there when you graduate?" (lines 169-170). In the second example, by asking, "and that's been important?" (line 741), White is asking about the importance of her support team that she had for her son Andrew. He did not make an immediate assumption that teamwork was important rather he asked the client. A more centered therapist usually would suggest that more support is needed and typically would provide referrals for additional support groups, may examine the quality of her support, or focus on Andrew's diagnoses and symptoms of her depression and so forth. White can be seen as collaborative by listening and checking-in with the client about her preferences and interests.

## Egalitarian

White seems to create egalitarian interaction with clients by being transparent, by asking for client's feedback, by asking clients to evaluate session, and by asking clients to evaluate problems. It appears that White can be categorized as egalitarian when taking a decentered position.

Supra-Themes	Themes	Sub-Themes
<u>EGALITARIAN</u>		
Therapist seems to create egalitarian relationship with clients by being transparent, and by asking for client's feedback. Therapist seems to create egalitarian relationship by inviting clients to evaluate session and provide their feedback. By asking clients to reflect and evaluate their problems, therapist creates egalitarian interaction.	Therapist seems to be transparent.	Therapist seems to be transparent about: a) the setting, b) the process of therapy, c) his experience of session, and d) his intentions.
	Therapist asks for client's feedback.	Therapist asks clients for their feedback about: a) the content of conversation, b) the setting, c) client's experience in the session, and d) the process of conversation.
	Therapist invites clients to evaluate session.	
	Therapist asks client to evaluate problems.	

**Therapist seems to be transparent.** White can be seen as being transparent about: a) the setting, b) the process of therapy, c) his experience in session, and d) his intentions.

### *Example 1 – about setting*

66 MW: = What do you think about all these

67 cameras and things? (2.3)

### *Example 2 – about the process of therapy*

263 MW: = to get into this sort of work \*yeah\* (.) So:

264 um and and you are already familiar with a

265 reflecting the team process [and (inaudible)]  
 266 D: [I've done it  
 267 some =

*Example 3 – about his experience in session*

357 MW: = I arrived yesterday, my world is still  
 358 going around in circles you know =  
 359 D: = you are in a completely different time =  
 360 MW: = if I ask the same question twice you know  
 361 that =  
 362 D: = ((laughs)) It's okay =  
 363 MW: = ((laughs)) =  
 364 D: = I'll answer the same question twice.

*Example 4 – about his intentions*

768 MW: [yeah. So:: (2.0) I made couple of notes  
 769 here and if that's okay and come back to  
 770 them  
 771 D: = sure =

Note: By being transparent, White seems to create a more egalitarian interaction. In contrast to a more centered therapist who may believe that clients should not be informed of therapist's intentions for healing to occur, White believed in importance of therapist's transparency that contributes to creating a more equalitarian interaction in which clients are not pathologized or seen as below therapist in any way.

**Therapist asks for client's feedback.** During the session, White can be seen to often ask clients for their feedback about: a) the content of conversation, b) the setting, c) the client's experience in the session, and d) the process of conversation.

*Example 1 – about the content of conversation*

1232 MW: ((laughs)) okay yeah (.) so um are we  
 1233 talking what's interesting to you to talk  
 1234 about or? =  
 1235 D: = uh-huh yeah it is =

*Example 2 – about the setting*

66 MW: = What do you think about all these  
 67 cameras and things? (2.3)

*Example 3 – about her experience in the session*

438 MW: So what's like it for you to be out here in  
 439 front of the group behind the one-way  
 440 screen? =

*Example 4 – about the process of conversation*

768 MW: [yeah. So:: (2.0) I made couple of notes  
 769 here and if that's okay and come back to  
 770 them  
 771 D: = sure =

Note: By asking clients for feedback about the content of conversation, about the setting, about the client's experience in the session, and about the process of conversation, White seems to create egalitarian relationship with clients.

**Therapist invites clients to evaluate session.** In this example, White asked the client to evaluate what she heard in the session from her mother.

*Example 1*

- 2608 MW: = was that acknowledgment from your  
 2609 mom? Was that a positive thing for you? =  
 2610 D: = yeah yeah it is. Actually to tell you the  
 2611 truth it opens up possibilities for further  
 2612 discussions for more conversation with my  
 2613 mom about that.

Note: In this example, White did not ask usual evaluative question, “Was this session useful to you?” or something similar. Instead toward the end of the session, he asked the client to evaluate what her mother specifically said during the session to see if that was useful for her identity conclusion or/and their relationship. A centered therapist may provide his or her expert evaluation of the session. I noticed that White did not do that, but instead, he asked the question, which makes him decentered.

**Therapist asks clients to evaluate problems.** Instead of making interpretations and evaluations for the client, White is asking the client to evaluate.

*Example 1*

- 998 D: (.3) How do you mean? I’m trying to  
 999 imagine how my relationship with it  
 1000 changed. (4.0) I think my hope (1.0) my  
 1001 relationship with hope in relation to  
 1002 Andrew has changed =



1003 MW: = \*yeah\* yeah can you tell me about that?

Note: White is taking a decentered position by asking the client to evaluate her relationship with hope. By being curious about the client's relationship with the problem and yet refusing to provide his expert evaluation of it, he is expressing a not-knowing/non-expert position as well as his post-structural worldview, which is part of being decentered. This stance also helps the client to become more curious and aware of her relationship with a "problem." A centered therapist usually would provide his or her evaluation in terms of individual or family diagnosis and typically focus on prescribing a direction for symptom reduction or family system perturbation or/and restructuring, transference and countertransference, and so on depending on their theoretical orientation.

*Example 2*

1656 MW: So this fears would have you do what?  
 1657 What sorts of things would these fears have  
 1658 you doing that can't get you to do now you  
 1659 know? =

*Example 3*

1746 MW: (2.3) So this fear that someone might find  
 1747 out that you are not being perfect =  
 1748 D: [yeah =  
 1749 MW: = [would be isolating  
 1750 D: = [I think to be honest >I mean< it has a lot  
 1751 to do with my family and not wanting my

1752 mom and dad to know certain things about  
 1753 [me that are personal =

Note: In examples 2 and 3, White asks the client to evaluate “this fear” and its consequences in her life. In contrast to centered therapists who might provide their understanding of the client’s fear and how it makes her depressed and unhappy or how it is a product of her irrational thoughts, a decentered therapist privileges the client’s understanding of the consequences of the problems on their lives and provides opportunities for clients to see themselves in relationship with the problem rather than in possession of it. As a result, clients may feel liberated and empowered to change the relationship to the problem.

#### **Non-Hierarchical/Not-Expert**

White seems to be a non-hierarchical or a not-expert in the interaction with the clients. He appears non-hierarchical by not attributing meaning to client’s problems, by not imposing his understanding about the consequences of the problems, by not-knowing in advance what is the best for clients and how they should live their lives, and by not providing his expert knowledge and judgment in terms of compliments, solutions, insight, and normalizing. He also appears a non-hierarchical by not prescribing directions for clients and avoids confronting clients about their beliefs. It appears that White is non-hierarchical when performing a decentered position.

Supra-Themes	Themes	Sub-Themes
<u>NON-HIERARCHICAL/ NOT-EXPERT</u>		
<p>Therapist refrains from taking a hierarchical position.</p> <p>Therapist tries to level hierarchy by respecting clients' meanings and understandings about their problems, by taking a decentered stance about what is the best for them and how they should live their lives, and by not providing his expert knowledge and judgment in terms of compliments, solutions, insight, and normalizing.</p> <p>Ultimately, clients are seen as experts on their lives, not therapists. White believed that there is a hierarchical difference between therapist and client but that there are many ways how therapist can try to level that hierarchy.</p>	Therapist refrains from attributing meaning to client's problems.	
	Therapist avoids imposing his understanding about the consequences of the problems.	
	Therapist does not act as a primary author in how clients should live their lives.	
	Therapist avoids prescribing directions for client.	
	Therapist holds back knowing in advance what is best for the client.	
	Therapist avoids providing solutions for client.	
	Therapist avoids providing compliments.	
	Therapist avoids providing his own insight.	
	Therapist avoids confronting clients about their beliefs.	Therapist avoids providing his own insight by asking questions and privileging client's voice, and by using editorial that includes client's languages, preferences and meanings.
	Therapist refrains from providing normalizing judgment.	

**Therapist refrains from attributing meaning to client's problems.** White does not assign meaning to the client's problems. Instead, he uses questions to find out from the client.

*Example 1*

- 1637 MW: = This is fear of? =
- 1638 D: [(ugh ohh)
- 1639 MW: = of upsetting someone or?
- 1640 D: = yeah >no you know< I had a lot of years
- 1641 of being really disciplined about food and
- 1642 [eating =
- 1643 MW: [(ohh okay)
- 1644 D: = and um and I think a lot of that was just
- 1645 fear of (.) expressing myself of who I was =
- 1646 MW: [right
- 1647 D: as a woman and >you know< whatever
- 1648 other capabilities (.4) all the other
- 1649 capabilities that I have =
- 1650 MW: = right =

Note: In this example, White was curious about the nature of her fear, and although he made a guess “of upsetting someone” he respected her attribution of meaning, that it is a “fear of expressing myself.” Centered therapists typically would provide their insight why she has this fear based on their theory; for example, her negative thoughts (cognitive therapy), unfinished business from a childhood (psychoanalysis), sense of inferiority (Adlerian), low differentiation of self (Bowen) and/or her suffering from an eating disorder, etc. White took a decentered position by being curious and privileging client’s local knowledge rather than his expertise.

**Therapist avoids imposing his understanding about the consequences of the problems.** In this example, White asks questions about client's understanding about the consequences of her problems.

*Example 1*

1656 MW: So this fears would have you do what?  
 1657 What sorts of things would these fears have  
 1658 you doing that can't get you to do now you  
 1659 know? =

Note: White takes a decentered position by asking questions about the consequences of the problem (fear) rather than imposing his own understanding of the consequences of her fear. It is also evident that White externalizes fear and asks indirectly about her skills and knowledges in overcoming the fear.

**Therapist does not act as a primary author in how clients should live their lives.** In the first example, White accomplishes this by asking questions, while in the second example he avoids providing suggestions how the client should live her life.

*Example 1*

1430 MW: = \*yeah okay\*. So how does that fit with  
 1431 um (.8) this changing relationship with  
 1432 hope? Are they connected this refusal to be  
 1433 so [disciplined and changing your  
 1434 relationship to hope?  
 1435 D: [ohhh you know it's something that is  
 1436 happening now =

- 1437 MW: [yeah
- 1438 D: = it's hard to say what
- 1439 MW: [yeah
- 1440 D: = I'm kind of wondering how it's gonna
- 1441 (3.8) >you know what it is though< it's
- 1442 kind of like hope that (1.2) well in allowing
- 1443 myself to to um have a different
- 1444 relationship with a discipline =

Note: In this example, White inspires curiosity in the client rather than provides his expert knowledge about the connection between her relationship with hope and her refusal to be so self-disciplined. It appears that, as a result, the client discovered something new about herself; she became aware how her changed relationship with hope influences her relationship with discipline. White is learning from the client by being curious about her own experience and does not assume that he knows what is the best for client.

### *Example 2*

- 1669 D: = >cause I guess it< made me feel like I had
- 1670 some control over my life =
- 1671 MW: = right I get it. \*yeah\*=

Note: In this example, the client was talking about her discipline about what she ate and the consequence of it: "I had some control over my life." White did not suggest treatment for eating disorders or offered diagnostic label for her problem. Instead, he just said, "right I get it. yeah." White did not suggest how she should live her life. He did not

ask her, how long she is having an eating disorder or/and about how she can have more control over her life without controlling her eating, as usually would the therapist operating from the centered position.

**Therapist avoids prescribing directions for client.** White seems non-hierarchical by not prescribing directions for the client. He avoids giving directions by asking questions.

*Example 1*

- 540 D: = I mean school's been really absorbing so  
 541 I get real absorbed in that =  
 542 MW: = and that's been helpful?  
 543 D: Yes.

Note: In this example, White is taking a decentered position by asking whether getting absorbed in school has been helpful for the client. He is not assuming that he knows that it is helpful, and he is not providing directions for the client. A centered therapist might think that the client is in denial by getting absorbed in work and not facing her "real" problems such as depression, or he might suggest that she should get absorbed even more in work without asking if that's been helpful for her. White is decentered by privileging client's inside knowledge and meanings and respecting her preference how she should live her life. Consequently, he can be seen as creating a non-hierarchical relationship with the client.

**Therapist holds back knowing in advance what is best for the client.** White is curious rather than knows in advance what is best for the client. In this example, he asks how question, instead of providing his expert knowledge, which makes him non-hierarchical.

*Example 1*

1620 MW: [>yeah yeah<  
 1621 How come that it is surprised to you? that=

Note: In this example, White asked if she was surprised that she is refusing to be so disciplined and then “how come” that it was a surprise to her. He holds back knowing what is the best for the client. A centered therapist might get excited and congratulate her on being able to refuse to be so disciplined or might suggest that discipline is a good thing for her. That way, the conversation would be closed, and the client’s voice and preferences would be shut down. A decentered therapist is curious and does not know in advance what is the best for the client.

**Therapist avoids providing solutions for client.** In this example, White avoids providing solutions by saying “yeah” and “right” while the client talked about her struggle and figuring out where to go from where she was.

*Example 1*

528 D: = and just struggling with all the things  
 529 about being a single parent and trying to  
 530 remake my life with difficulties of having  
 531 any children just particularly difficulties  
 532 that I (.) have with my boys =  
 533 MW: = yeah =  
 534 D: = and I’m (.) just trying to (1.8) um figure  
 535 out where to go from here.  
 536 MW: \*right\* =



Note: In this example, White is decentered by not providing solutions how she should remake her life, live as a single parent, and address difficulties with her children.

Therapists may have different ideas about what can be helpful for the client, and as a result, they may provide solutions. During the session, there were many opportunities for White to provide solutions for the client, but I noticed that he did not do it. A more centered therapist typically would provide his or her insight, suggestions, and solutions.

**Therapist avoids providing compliments.** In this example, White avoids providing a compliment by asking the how type of question.

*Example 1*

1110 D: = yes I am trying to do [that

1111 MW: [yeah (.)

1112 \*okay all right.\* How did you achieve that?

Note: The client expressed that her social life is getting better, and that she is trying to allocate more hope to herself. White did not take a centered position by saying that was a great thing; instead, he asked the question to create an opportunity for the client to more richly describe her alternative story. Even though White mostly avoids compliments, I found that there were few times when White was more centered by complimenting Mathew's good behavior.

**Therapist avoids confronting clients about their beliefs.** White respects the client's beliefs and does not try to challenge the client in both examples below.

*Example 1*

762 D: = and uhh (1.5) it does it gives me you

763 know it gives me that sense of purpose =

- 764 MW: = yeah right =
- 765 D: = that I that's really important =
- 766 MW: = important? =
- 767 D: [yeah

Note: The client talked about how getting absorbed in schoolwork gives her a sense of purpose. White did not confront that belief. He agreed with her by saying, "yeah right." By respecting the client's interpretations and meaning a therapist is decentered. A more centered therapist might challenge her and see her getting absorbed in work as an escape from real problems.

*Example 2*

- 894 D: .....
- 895 (.3) I think school gave me a sense of (2.2)
- 896 esteem that I was starting >that was being <
- 897 eroded in my marriage ((nodding)) =
- 898 MW: = ((nodding)) hmm okay =

Note: White did not challenge the belief that her marriage eroded her self-esteem. He wasn't interested in asking about the history of her low self-esteem or trying to help her gain more self-esteem. Instead, he respects her interpretations and her expert knowledge on her experience.

**Therapist avoids providing his own insight.** White avoids providing his insight by: a) by asking questions and privileging client's voice, and b) by using editorial that includes client's language, preferences, and meanings.

*Example 1 – by asking questions and privileging client’s voice*

834 MW: = \*yeah\* so what sorts of things would you  
 835 be (valuating in) yourself (.5) for when you  
 836 are able to reflect on this? =

*Example 2 - by using editorial that includes client’s language, preferences, and meanings*

1302 MW: You mentioned that (.7) um medication  
 1303 helped a bit to get you out of spot=  
 1304 D: [uh-huh  
 1305 MW: =that you were in (.4) but you haven’t  
 1306 experienced going back there again =  
 1307 D: = yeah =  
 1308 MW: = and we talked about how you changed  
 1309 your relationship to hope and =  
 1310 D: ((nodding))

**Therapist refrains from providing normalizing judgment.** In this example, White avoids providing his expert evaluation and normalizing the client’s situation or problems.

*Example 1*

614 D: = and I was feeling just really overwhelmed  
 615 with (1.4) Andrew and how I was gonna  
 616 continue to take care of him cause  
 617 physically is getting hard =  
 618 MW: = yeah =

619 D: = and Mathew's got lots of >lots of lots of  
 620 < energy =  
 621 MW: = yeah yeah =  
 622 D: = yeah and his own uniqueness ((laughs))  
 623 (1.3) and um (1.5) I just felt like (.5) how  
 624 was I gonna be able to get through the day  
 625 no less the years and wondering too how  
 626 and also struggling with how's gonna  
 627 remake my own life >you know< I would  
 628 love to have (1.2) a relationship again  
 629 someday and I am overwhelmed with  
 630 would anyone want to come in to the  
 631 situation >you know< it's (2.2) ah so I was  
 632 feeling kind of depressed around that =  
 633 MW: = yeah yeah \*okay\* so \*wow\* so can I just  
 634 check now with Andrew how's Andrew  
 635 now? His pain is that =

Note: In this example, White did not provide normalizing judgment by evaluating her situation or by diagnosing her children with ADHD and physical disability nor did he say that what she was experiencing is normal. Thus, he refrains from providing normalizing judgment. White is not asking questions that would thicken the client's problem-saturated story. Instead, he was curious about Andrew and said, "yeah okay" few times to indicate that he heard her.

**Non-Pathologizing/Post-Structuralist View**

It appears that White's decentered position includes a non-pathologizing and a post-structuralist view. White refuses to objectify and categorize clients, he avoids providing diagnosis for the client's problems, he refuses to see them in totalizing ways and as having internal structures that need to be fixed. White has a non-pathologizing and post-structuralist view because he rejects trying to fix clients into becoming normal; instead, he sees them acting according to their intentions, hopes, dreams, beliefs, aspirations, values, and goals. White is also decentered by not seeing problems in totalizing ways and by avoiding simplistic behavioral goals.

Supra-Themes	Themes	Sub-Themes
<u>NON-PATHOLOGIZING</u> <u>/POST-STRUCTURALIST</u> <u>VIEW</u> Therapist refuses to objectify and categorize people and to see them in totalizing ways because he is not seeing them as having internal structures that need to be fixed into becoming less pathological or normal. This position is informed by post-structuralist world-view. Therapist refuses to reproduce dominant discourse and avoids simplistic behavioral goals. Therapist sees clients as acting according to their intentions, values, beliefs, plans, hopes, aspirations, goals, and dreams.	Therapist avoids providing diagnosis for client's problems and avoids objectifying the client.	
	Therapist refuses seeing client in totalizing ways.	
	Therapist refrains from seeing clients as having internal structures.	
	Therapist avoids categorizing people.	
	Therapist rejects trying to fix people into becoming normal.	
	Therapist avoids asking questions that verify client deficiency or inadequacy.	
	Therapist avoids seeing problems in totalizing ways.	
	Therapist avoids simplistic behavioral goals.	
	Therapist sees clients as acting according to their intentions, values, beliefs, hopes, dreams, aspirations, and/or goals.	

**Therapist avoids providing diagnosis for client's problems and avoids objectifying the client.** In this example, White asks the client about her relationship with hope, rather than objectifying her with hopelessness or diagnosing her with depression.

*Example 1*

1064 MW: = but I was thinking about your relationship

1065 with hope yeah]

- 1066 D: = yeah thinking about how it has changed  
 1067 yeah]  
 1068 MW: = and just wondering whether or not  
 1069 coming out of this um (1.6) down time that  
 1070 you had whether you come out with a  
 1071 different sort of a relationship to hope um =

Note: White is decentered by not-pathologizing the client and by seeing her in relationship with hope, which creates a sense of personal agency and empowerment that she can do something about it. That is based on his post-structuralist view. A centered therapist may diagnose her with depression and try to help her become more hopeful.

**Therapist refuses seeing client in totalizing ways.** In both examples, White does not see the client in possession of the problem and as having a defective personality that needs to be healed. He refuses to see her in totalizing way by asking about her relationship with the problem.

*Example 1*

- 1656 MW: So this fears would have you do what?  
 1657 What sorts of things would these fears have  
 1658 you doing that can't get you to do now you  
 1659 know? =

*Example 2*

- 2258 MW: = Could you ever imagine yourself  
 2259 (reveling) in imperfection? =

Note: In the first example, White does not see the client as fearful and asks the questions about how the fears influence her or not influence her anymore. In the second example, White does not see her as imperfect, but rather asks her about “(reveling) in imperfection,” which also indicates his non-pathologizing and post-structuralist view.

**Therapist refrains from seeing clients as having internal structures.** In this example, White is curious about mother’s relationship with perfection.

*Example 1*

2629 MW: ..... And I also wondered whether  
 2630 um (1.4) um its been an issue for you as  
 2631 well Dorothy >you know< in your life to  
 2632 challenge (.6) this notion of perfection?

Note: White saw the client in a relationship with the problem (perfection) rather than in possession of it. From his question, it is evident that he does not perceive clients as having internal structures. This is consistent with his non-pathologizing view of people who come for consultation and his post-structuralist worldview.

**Therapist avoids categorizing people.** In this example, White informs the client about his intentions and that the client will not be categorized in any way because the focus is on the process.

*Example 1*

285 MW: = and focus on the process rather than on  
 286 you personally so: (1.2) group will be making  
 287 comments and asking questions about the  
 288 interview itself.



Note: White is decentered by not only refusing to see the client as having internal structures that need to be “fixed” but also by informing her that she will not be categorized.

**Therapist rejects trying to fix people into becoming normal.** In this example, White is not asking questions to fix client’s problem with eating and control. He was just listening and did not try to change the client into becoming “normal”.

*Example 1*

- 1660 D: = um (1.7) well particularly around food  
 1661 just not wanting to be real disciplined about  
 1662 what I ate and not wanting to (2.0) um >you  
 1663 know< eating only what I was decided I  
 1664 was going to eat that day and that kind of  
 1665 thing =  
 1666 MW: = right okay =  
 1667 D: = be really controlled about it =  
 1668 MW: = \*yeah\* =  
 1669 D: = >cause I guess it< made me feel like I had  
 1670 some control over my life =  
 1671 MW: = right I get it. \*yeah\*=

Note: White neither diagnosed the client with an eating disorder, nor he tried to fix it. He is decentered by not imposing his beliefs and values how people should be and what constitutes a normal behavior.

**Therapist avoids asking questions that verify client deficiency or inadequacy.** In this example, White was curious about Andrew and their intentions and plans for him. White did not ask questions about Andrew's physical and mental disabilities and his seizure disorder; about the intensity and frequency of his symptoms as usually would a centered therapist focused on diagnosing and treating diseases. He also asked about Mathew's plan for future.

*Example 1*

- 365 MW: so um (.) yeah and so (.) What happens with  
 366 Andrew? I know that (.) is Mathew be  
 367 going off to a place school or something?  
 368 [What happens to him?  
 369 D: [He is in the preschool =

Note: White is decentered by avoiding questions that would verify the client's inadequacy or/and deficiency. Instead, he asks about their intentions, plans, goals, etc. White was curious to get to know them outside of "what's the problem with your children" way of thinking.

**Therapist avoids seeing problems in totalizing ways.** White does not see problems as all good or all bad.

*Example 1*

- 996 MW: Sure >yeah< sure I wasn't thinking that it  
 997 wasn't helpful force in your life

*Example 2*

- 1061 MW: ye:ah I think hope is really important I



461           because I (.5) you know I don't have much  
 462           information about =  
 463 D:       = uh-huh =

Note: White had spent approximately fifteen minutes getting to know clients before he asked this question. He did not ask in the beginning of the session the standard questions such as, "How can I help you today?" or "What is your goal for today's session?" or something similar. Throughout the entire session, White did not appear as a therapist who is interested in changing client's behavior.

*Example 2*

528 D:       = and just struggling with all the things  
 529           about being a single parent and trying to  
 530           remake my life with difficulties of having  
 531           any children just particularly difficulties  
 532           that I (.) have with my boys =  
 533 MW:      = yeah =  
 534 D:       = and I'm (.) just trying to (1.8) um figure  
 535           out where to go from here.  
 536 MW:      \*right\* =

Note: After the client reported her struggles about being a single parent and trying to remake her life, White avoided simplistic behavioral goals to fix her problems. He did not ask questions such as: What can you do to remake your life? Was there a time you felt good as a single parent? Or to suggest her to do more of what was working. White

didn't set or asked for a behavioral specific and measurable goal, instead he was curious about her experience of being a single mother and her preferred story.

**Therapist sees clients as acting according to their intentions, values, beliefs, hopes, dreams, aspirations, and/or goals.** In both examples, White is curious and asks questions about the client's goals, aspirations, and values.

*Example 1*

- 158 MW: = I just met her briefly (1.3) and a and a  
 159 you are in the program [here?  
 160 D: [uh-huh] yeah  
 161 graduating in couple of months =  
 162 MW: = Are you really? =  
 163 D: = yeah =  
 164 MW: = yeah wow is that after how long? How  
 165 long is the program been? =  
 166 D: Two years =  
 167 MW: = Two years \*yeah\*=  
 168 D: yeah.  
 169 MW: And where do you go from there when you  
 170 graduate?  
 171 D: Well then I have to do my internship hours  
 172 I have to (1.1) accrue three thousand hours  
 173 [before I can =  
 174 MW: [thr::ee thousand!

- 175 D: = yes (laughs) =
- 176 MW: = before [before you?
- 177 D: [before I can take a licensing exam
- 178 MW: = really?
- 179 D: yeah ((nodding and smiling))
- 180 MW: (inaudible) How long will that take? =

*Example 2*

- 1545 D: = but um (2.9) I don't know I just feel more
- 1546 open to and I really enjoy (1.5) having the
- 1547 people around me and my family we are
- 1548 very close family =
- 1549 MW: = \*uh-huh\* =
- 1550 D: = and um that's really important to me =
- 1551 MW: = right so that's >that's< more valuable to
- 1552 you that sense now than it was? =

Note: White is decentered by not-pathologizing the client and by being curious about her goals and ambitions. In the first example, he was curious about her education and goals for future, and in the second example, he asks about her values – her sense of being open and having close family. I noticed that White seemed like he was getting to know the clients throughout the session, rather than trying to “fix” them. Based on the questions he asked, it also appears that he sees clients as acting according to their hopes, dreams, values, intentions, goals, beliefs, and aspirations.

## Curiosity

White's curiosity, while performing a decentered stance, is evident in all themes mentioned above. He mostly asked questions and he avoided making statements and giving advice. It appears that curiosity is a way of performing and being in a decentered position.

Supra-Themes	Themes
<u>CURIOSITY</u> Therapist mostly asks questions, and mostly avoids making statements and giving advice	Therapist mostly asks questions.  Therapist mostly avoids making statements and giving advice.

### **Therapist mostly asks questions.**

If a reader takes a look at examples in all other themes, he/she will notice that White mostly asks questions when he is performing a decentered stance. So it is evident that he is decentered by mostly asking questions. However, he is not only performing other themes by asking questions, asking questions is a way of being decentered. On the other hand, asking any question does not make a therapist automatically decentered. Therapists can ask mostly questions that reveal their centered position, for example, if they ask clients questions that verify their deficiency or inadequacy.

### **Therapist mostly avoids making statements and giving advice.**

It is evident throughout the entire transcript or in all other themes that White is decentered by avoiding statements and giving advice. Instead, White performs decentered stance with curiosity.

## Influential Position

### Co-Researcher and Co-Creator of Context for Rich Story Development/ Narrative

#### Metaphor

White can be seen as influential by providing opportunities for clients to deconstruct their dominant story, to more richly describe their alternative stories, and to step into and explore some neglected territories of their lives. While performing these themes or ways of being influential, White acts as a co-researcher and co-creator of context for rich story development. These influential themes are influenced by narrative metaphor.

Supra-Themes	Themes
<u>CO-RESEARCHER AND CO-CREATOR OF CONTEXT FOR RICH STORY DEVELOPMENT/ NARRATIVE METHAPHOR</u> Therapist is influential by providing opportunities for clients to deconstruct their dominant story, to more richly describe alternative stories, and to step into and explore some neglected territories of their lives.	Therapist provides opportunities for clients to more richly describe the alternative stories of their lives.  Therapist provides opportunities for clients to step into and to explore some of the neglected territories of their lives.  Therapist provides opportunities for clients to deconstruct their dominant story.

#### **Therapist provides opportunities for clients to more richly describe the alternative**

**stories of their lives.** In these examples, White uses questions or editorial to provide opportunities for the client to more richly describe her alternative story that includes her possible changes (example 1), and being more open (example 2). White is curious about anything outside the client's problem-saturated story.



*Example 1*

963 MW: ..... (1.3) You know  
 964 you mention that (.9) you did have this low  
 965 time but (.3) you actually came out of that  
 966 (.4) being absorbed in your work helped a  
 967 lot. >I was wondering if there were< some  
 968 other things as well that changed for you?

Note: White used editorial and then asked the unique outcome question, “I was wondering if there were some other things as well that changed for you?” which provides the opportunity for the client to reflect on and be curious about what else changed for her. It is a question that opens space for creating an alternative more preferred story.

*Example 2*

1705 MW: (.9) so: (1.0) okay is this something that  
 1706 you could have done like this six months  
 1707 ago? or twelve months ago? (.) talk so  
 1708 openly about =

Note: When White heard about the unique outcome that she is “being more open about things,” he did not compliment her, but instead, he asked her more questions to participate in the co-creation of her alternative story by acquiring about her perception of the difference in her identity conclusion, “is this something that you could have done like six months ago?” By doing that he is respectful of her knowledge and skills and stimulates her to think about what made that possible. The client perceives herself as more open and White is being influential by thickening that story.

**Therapist provides opportunities for clients to step into and to explore some of the neglected territories of their lives.** In the first example, White asks the client if she is surprised that she is refusing to be so disciplined which can lead to exploring new or neglected aspects of her life. In the second example, White first used the closed-question “did you know” and then more specific follow-up question to ask her mother about her role in helping her daughter refuse to be so disciplined, change relationship with hope, and challenge the expectations.

*Example 1*

1613 MW: .....  
 1614 .....< are you surprised that to (1.0) um  
 1615 (.5) you know acknowledged the fact that  
 1616 you are refusing to be (.9) um (.9) so  
 1617 disciplined or? is that surprise to you? or  
 1618 isn't? =

Note: White is influential by asking the question, “are you surprised...” in order to get more details and learn from and with the client about how it was possible for her to refuse to be so disciplined. In other words, what made that possible, which leads to a new knowledge and unknown territory what client might know about her identity.

*Example 2*

2052 MW: Did you >did you< were you aware that  
 2053 you played some role in in (that)? =  
 2054 Do: = I certainly know that I play a role in my  
 2055 children's lives =

- 2056 MW: = yeah =
- 2057 Do: = you know to know to what extent I think
- 2058 a parent really doesn't always know to what
- 2059 extent (.2) and I hope that Diane knows that
- 2060 I'm always there even if it's telephone call=
- 2061 MW: = I guess I was meaning specifically did
- 2062 you know that you played some role in
- 2063 helping Diane to (.9) enter into this refusal
- 2064 of disciplining herself so much and to (.)
- 2065 challenge the [expectations =
- 2066 Do: [no, not really
- 2067 MW: = change her the relationship with hope?
- 2068 Do: [not really =

Note: White clarifies by being more specific and in this example, he is trying to be influential by asking about the mom's contribution to the client's refusal to be so disciplined, to her challenging the expectations, and to her changed relationship with hope in order to co-create an alternative story about their relationship and to thicken Diane's preferred identity conclusion. By asking these questions he invites mother to explore some neglected territories of their relationship.

**Therapist provides opportunities for clients to deconstruct their dominant story.** In this example, White asked the mother about her daughter's imperfection to provide opportunities for clients' to deconstruct the dominant story – her struggle with trying to be perfect.

*Example 1*

2241 MW: = Are there any time in Diane's life with  
 2242 you you ever experienced her um (.9)  
 2243 (raveling) in imperfection? Can you ever  
 2244 recall a time when Diane was imperfect? =

Note: Since the client reported that she had feared being perceived as not being perfect, and that she has been experimenting with not being so disciplined, White asks in this example about the possible unique outcome. He asks mother if she remembers a time when her daughter was imperfect. White was not influential by saying that mother should support her to accept her imperfection. Rather he asked the question to open the conversation for co-creating the alternative identity conclusion.

**Co-Creator of Context for Preferred Identity Conclusion/ Post-Structuralism**

White can be seen as a co-creator of context for preferred identity conclusion when he performs the influential stance. White is influential by providing opportunities for the client to redefine her relationship with the problem and to re-experience and create a more preferred identity conclusion. This is based on a post-structuralist view of identity. White is influential by objectifying client's problems and asking questions about the client's hopes, dreams, intentions, aspirations, and preferences. He is also influential by assisting clients to move from what is known and familiar to what might be possible for client to know about his/her life and identity.

Supra-Themes	Themes
<p><u>CO-CREATOR OF CONTEXT FOR PREFERRED IDENTITY CONCLUSION / POST-STRUCTURALISM</u></p> <p>Therapist is influential by creating a context in which clients have opportunities for re-experiencing their identity and creating a more preferred identity conclusion. This is based on a post-structuralist view of identity. Therapist is influential by objectifying client's problems and asking questions about client's hopes, dreams, intentions, aspirations, and preferences. Therapist is also influential by assisting clients to move from what is known and familiar to what might be possible for client to know about his/her life and identity. By providing opportunities for client to revise the relationship with the problem, clients may experience their preferred identity.</p>	<p>Therapist provides opportunities for clients to redefine their relationship with the problem and/or to re-experience their identity.</p> <p>Therapist provides opportunities for clients to create a more preferred identity conclusion.</p> <p>Therapist assists clients to move from what is known and familiar to what might be possible for him or her to know about his or her life and identity by asking questions.</p> <p>Therapist asks questions that seem to lead to learning something new or neglected about clients' hopes, dreams, intentions, aspirations, and preferences.</p> <p>Therapist objectifies client's problems.</p>

**Therapist provides opportunities for clients to redefine their relationship with the problem and/or to re-experience their identity.** In this example, White provides this opportunity by asking about the client's different relationship with hope.

*Example 1*

- 1068 MW: = and just wondering whether or not
- 1069 coming out of this um (1.6) down time that
- 1070 you had whether you come out with a
- 1071 different sort of a relationship to hope um =
- 1072 D: = yeah =
- 1073 MW: = and what you sort of \*relationship\*?

Note: During the conversation, White made it possible for her to evaluate when the hope is good and when it is not so good for her. In these questions, "whether you come out

with a different sort of relationship...and what sort of relationship” White provides opportunities for the client to think about herself as separate from the problem and to redefine her relationship with the problem.

**Therapist provides opportunities for clients to create a more preferred identity**

**conclusion.** White appears to do that by asking question in example 1 and by using editorial in example 2.

*Example 1*

- 847 D: = and my intellectual capabilities that they  
 848 are still intact despite of having giving birth  
 849 to two children ((laughs)) which I  
 850 sometimes doubt it that it was there  
 851 ((smiles))  
 852 MW: So put you back in touch with that?

Note: In this example, White is influential by asking a follow-up question that helps the client get in touch with her more preferred identity conclusion that she has intellectual capabilities.

*Example 2*

- 1525 MW: = right okay so um (1.0) that helps me  
 1526 understand so it made a lot easier for you to  
 1527 be who you are (.8) and: just being with  
 1528 people and (.8) um =  
 1529 D: = uh-huh =  
 1530 MW: = not >not< um sort of having to fit with

1531 certain expectations about who you should  
1532 be [or something like that, is that it?

Note: In this example, White used editorial to influence a co-creation of her preferred identity conclusion, which is about not fitting certain expectations of perfection. In his editorial, White includes client's voice and preferences about who she wants to be.

**Therapist assists clients to move from what is known and familiar to what might be possible for him or her to know about his or her life and identity by asking questions.** In the first example, White uses the how question and in the second example, he uses clarifying question to move the client from what is known and familiar to what might be possible for her to know about her life and identity.

### Example 1

1110 D: = yes I am trying to do [that  
1111 MW: [yeah (.  
1112 \*okay all right.\* How did you achieve that?

## Examples 2

1377 MW: [\*okay right okay good\* um (2.0) in terms  
1378 of the self-esteem that you mentioned that  
1379 you're being reclaiming and sense of  
1380 accomplishment getting more in touch with  
1381 your own (self) would you say self-  
1382 discipline is that what you meant when you  
1383 said discipline or?  
1384 D: umm (2.6)

1385 MW: you said discipline and creativity =

Note: In these examples, White created an opportunity for the client to move from what is known and familiar to what might be possible for the client to know in terms of how she can achieve new things and about her creativity and self-discipline. By asking these small questions White participates with the client in traversing from what is known and familiar to what might be possible to know about her life and identity.

**Therapist asks questions that seem to lead to learning something new or neglected about clients' hopes, dreams, intentions, aspirations, and preferences.** In the first example, White asks about the client's ambition and whether it was a shift for her, which leads to learning something new about her hopes and preferences. In the second example, White summarizes what he heard which led to learning that sense of a goal and accomplishing things is important to the client.

*Example 1*

222 MW: = \*yeah yeah\* has that been your ambition  
 223 for some time? or is that a recent (.4) recent  
 224 shift for you? =

Note: In this example, White is curious about the client's dreams and aspirations. He sees people acting according to their intentions and values rather than according to their internal structures. White asks the question, "is that a recent shift for you?" that seems to lead to learning something new or neglected about client's aspirations.

*Example 2*

906 MW: = right, so it's a matter of >sort of<  
 907 reclaiming some things that you wouldn't =



- 908 D: = uh-huh =
- 909 MW: = lost not lost but would be buried =
- 910 D: = uh-huh =
- 911 MW: = around your experiences.
- 912 D: And I think too a sense of a goal and
- 913 working toward accomplishing it =

Note: In this example, White used editorial to be influential in assisting the client to learn something neglected, that “a sense of a goal and working toward accomplishing it” is very important to her, and that school gave her that experience.

**Therapist objectifies client’s problems.** White objectifies the client’s problem by asking questions in which problems may have influence on a client, as “fear” in this example, which puts the client in a relationship with the problem.

*Example 1*

- 1656 MW: So this fears would have you do what?
- 1657 What sorts of things would these fears have
- 1658 you doing that can’t get you to do now you
- 1659 know? =

Note: White is influential by objectifying the fear and by asking, “What sorts of things would these fears have you doing that can’t get you to do now you know?” This question not only separate the person from the problem, but contributes to personal agency that the client can do something about “this fear”. Furthermore, by objectifying problems, the client can become aware of what the problem requires from her, whether she is okay with that or not, etc. White’s influential position includes the post-structuralist worldview.

### Co-Creator of Context for Reflection, Discovery, Learning, and Personal Agency

White, as a co-creator of context for reflection, discovery, learning, and personal agency, is influential by providing opportunities for clients to become more significantly acquainted with the knowledges and skills of their lives that are relevant to addressing the concerns, predicaments and problems that are at hand, and by asking questions that open possibilities for clients to pursue what they value and hold precious. He also creates context for reflection, discovery, learning, and personal agency by refraining from imposing his agenda and delivering interventions and by avoiding to ask questions that seem to lead to known knowledge.

Supra-Themes	Themes
<p><u>CO-CREATOR OF CONTEXT FOR REFLECTION, DISCOVERY, LEARNING AND PERSONAL AGENCY</u></p> <p>Therapist is influential by providing opportunities for clients to become more significantly acquainted with the knowledges and skills of their lives that are relevant to addressing the concerns, predicaments and problems that are at hand, and by asking questions that open possibilities for clients to pursue what they value and hold precious. Therapist also creates context for reflection, discovery, learning, and personal agency by refraining from imposing his agenda and delivering interventions and by avoiding to ask questions that seem to lead to known knowledge.</p>	<p>Therapist provides opportunities for clients to become more significantly acquainted with the knowledges and skills of their lives that are relevant to addressing the concerns, predicaments and problems that are at hand.</p> <p>Therapist avoids asking questions that seem to lead to known knowledge.</p> <p>Therapist refrains from imposing his or her agenda and delivers interventions.</p> <p>Therapist asks questions to open possibilities for clients to pursue what they value and hold precious.</p>

**Therapist provides opportunities for clients to become more significantly acquainted with the knowledges and skills of their lives that are relevant to addressing the concerns, predicaments and problems that are at hand.** In the first example, White asks the how question, how is something helpful to the client, like being absorbed in the school, which she previously reported. In the second example, White asks how she is able to achieve something in particular situation, which can also lead to learning about her skills in addressing her problems.

*Example 1*

544 MW: How's that being helpful?

545 [absorbing

*Example 2*

1413 MW: ((writing notes while she was talking))

1414 Okay, how are you achieving that in a

1415 situation that's? =

1416 D: = well I think I can talk about it in a relation

1417 to school I mean I always I allow myself to

1418 say well I can take extension on a paper I

1419 never done that before ((smiles))

Note: In both examples, White asked how questions. How is the client able to do certain things? Such exploration usually reveals information about the client's skills and knowledges that could help her with addressing her problems. These "how" questions also stimulate personal agency and learning something new about one's skills that could contribute to co-construction of a more preferred identity conclusion.

**Therapist avoids asking questions that seem to lead to known knowledge.** In this example, White's open-ended question led to a pause and a deeper reflection by the client.

*Example 1*

- 834 MW: = \*yeah\* so what sorts of things would you  
 835 be (valuating in) yourself (.5) for when you  
 836 are able to reflect on this? =  
 837 D: umm I think (.7) um (1.3) one thing is the  
 838 discipline that I had to [sit down and do this  
 839 MW: [right yeah \*yeah\*  
 840 D: = to (take) out the time for myself to do  
 841 that =

Note: White's question "what sort of things would you be (valuating in) yourself for when you are able to reflect on this?" made the client think and pause for few seconds. It required a deeper reflection about her identity and what she values.

**Therapist refrains from imposing his or her agenda and delivers interventions.**

White is not influential by expecting particular answers or by delivering interventions in a form of making suggestions. He is influential by being decentered as well.

*Example 1*

- 984 MW: [no no I am not looking for any  
 985 particular answer I am interested in what  
 986 you are interested in talking about and =

Note: This theme is part of being decentered too. White asks for the clients' preferences and how they prefer to lead their lives according to their beliefs, values, hopes, intentions, etc. White is influential not by imposing his views but rather by asking questions, by seeing clients as separated from problems, and by co-authoring alternative stories and more preferred identity conclusions.

**Therapist asks questions to open possibilities for clients to pursue what they value and hold precious.** In the first example, White asks questions, while in the second example, he provided hypothetical scenario to open possibilities for the client to pursue what she values.

*Example 1*

786 MW: So: (1.4) um (1.3) the getting absorbed in a  
 787 work gave that sense of purpose that was  
 788 really important to you, what (.) how would  
 789 you name the purpose? I mean what what =  
 790 D: = umm (2.2) how I name it? (4.2)  
 791 MW: ((White puts his notes on the ground))  
 .....  
 799 D: = you know what's most (inaudible) me is  
 800 the sense of self-esteem and keeping it in  
 801 tack and feeling like I really accomplish  
 802 something. It's really important >it's  
 803 always been< important to me =  
 804 MW: = yeah \*yeah\* =

805 D: = and with kids >you know< when  
 806 sometimes at the end of the day is like what  
 807 did I accomplish? >you know< =

Note: In this example, White is influential by opening possibilities for client to pursue what she holds precious and what is important to her - and that is, to feel accomplished. Even though White did not get an answer how she would name the purpose, she revealed that a sense of self-esteem has been always important to her.

*Example 2*

2264 MW: = yeah? I was just wondering (.4) um I am  
 2265 not going to ask you to imagine how you  
 2266 might do that at this point (.4) but if you  
 2267 were to (reveling) in imperfection and  
 2268 experienced um applause from your mom  
 2269 in relation to that >or not applause< but just  
 2270 really appreciation for that (.) would that  
 2271 make a difference to you?

Note: In this example, White is influential by thickening her efforts to refuse to be perfect. He provided a hypothetical scenario and asked if getting an appreciation from her mother for “reveling in imperfection” would make a difference for her. White also externalized the imperfection, which puts the client in relationship with it rather than in possession of it, which would be the case if he had said when you were being imperfect. It shows his post-structuralist worldview.

### **Part Three: Surprises**

So far I explored and described many ways how White can be seen to take a decentered and influential position based on the literature review of what he said about this stance and my inclusion criteria (see Appendix A). Given that the data analysis was approached with open mind and discovery attitude, I found additional ways how White can be seen to perform decentered and influential stance. These new themes (or ways of doing decentered and influential stance) are listed in Table 3 and Table 4 below, and they are further explained and supported by the exemplars from the transcript that follows the presented tables. In addition, the new decentered and influential themes with exemplars are annotated with my interpretations.

Table 3

*Michael White's Decentered Position New Themes*

Supra-Themes	Themes
<u>EGALITARIAN</u> Therapist seems to create egalitarian relationship with clients by asking them to reflect and evaluate unique outcomes, by asking them to evaluate new development or unique outcome around identity conclusion, and by asking them to evaluate reflecting team conversation.	Therapist asks client to reflect and evaluate unique outcomes.  Therapist asks client to evaluate new development or unique outcome around identity conclusion.  Therapist asks client to reflect and evaluate reflecting team conversation.
<u>NON-HIERARCHICAL/</u> <u>NOT-EXPERT</u> Therapist avoid imposing his understanding about the consequences not only problems but also unique outcomes. Therapist is taking a non-expert position and therefore creates non-hierarchical interaction with clients.	Therapist avoids imposing his understanding about the consequences of the unique outcomes.



Table 4

*Michael White's Influential Position New Themes*

Supra-Themes	Themes
<u>CO-RESEARCHER AND CO-CREATOR OF CONTEXT FOR RICH STORY DEVELOPMENT/ NARRATIVE METHAPHOR</u> Therapist is influential by co-creating a context for rich story development by asking about and highlighting unique outcomes, by highlighting the effects of unique outcomes and by writing down any reported changes or unique outcomes.	Therapist (asks questions) or highlights events outside of problem-saturated story or unique outcomes.  Therapist highlights the effects of unique outcomes reported by client on their lives.  Therapist writes down unique outcomes or any reported changes.
<u>RELATIONAL VIEW OF IDENTITY/ SOCIAL CONSTRUCTION</u> Therapist is influential by providing opportunities for clients to reflect on and evaluate the contributions of other people in development of their preferred identities and by asking family members if they have noticed any preferred changes, which may contribute to thickening of client's preferred identity conclusion and is based on relational view of identity and social construction. This is based on a perspective that identities are social achievement created in relationships and through language.	Therapist provides opportunities for client to reflect and experience preferred identity conclusion by asking if other people in client's life know or have noticed about their changes.  Therapist provides opportunities for clients to reflect on and evaluate the contributions of other people in their lives on development of their preferred identity conclusion.  Therapist asks question to family member which contributes to creating or/and thickening client's preferred identity conclusion.

## White's Decentered Position New Themes

### Egalitarian

According to my conversation analysis, White seems egalitarian in the interaction with the clients by asking them to reflect and evaluate unique outcomes, by asking them to evaluate new a development or unique outcome around identity conclusion, and by asking them to evaluate reflecting team conversation. These themes emerged from data and were not included in the initial themes for the decentered position.

Supra-Themes	Themes
<u>EGALITARIAN</u> Therapist seems to create egalitarian relationship with clients by asking them to reflect and evaluate unique outcomes, by asking them to evaluate new development or unique outcome around identity conclusion, and by asking them to evaluate reflecting team conversation.	Therapist asks client to reflect and evaluate unique outcomes.  Therapist asks client to evaluate new development or unique outcome around identity conclusion.  Therapist asks client to reflect and evaluate reflecting team conversation.

**Therapist asks client to reflect and evaluate unique outcomes.** In this example, White asks the client to evaluate her different relationship with hope, if it's a positive development for her.

#### *Example 1*

- 1176 MW: [would you say more recently?
- 1177 Would you say it's a positive development?
- 1178 That hope doesn't extend your (inaudible) your
- 1179 limits so much? =
- 1180 D: [I think so because I think it's real

Note: White is decentered not only when he asks clients to evaluate their problems but also when he asks them to evaluate unique outcomes. By privileging the client's voice in this way, White can be seen in the egalitarian relationship with the client. A centered therapist usually would not ask these kinds of questions because he or she would assume that these were positive developments.

**Therapist asks client to evaluate new development or unique outcome around identity conclusion.** In this example, White asks the client to evaluate her new development around identity conclusion – being more open to people.

*Example 1*

1716 MW: = Do you see the increase in openness as a

1717 positive thing or negative thing? =

1718 D: = I think it's a positive thing =

Note: White is decentered by asking this evaluative question for unique outcome around her identity conclusion, “the increase in openness” which she reported. White did not suggest that being more open is a good thing for her. A more centered therapist would usually state his or her expert opinion about what is good or bad thing for the client. It is possible that clients feel more understood, and that they discover what is important for them if they have been asked these evaluative questions that bring forth their voices instead of a therapist's expert knowledge.

**Therapist asks client to reflect and evaluate reflecting team conversation.** In this example, White asks the clients to evaluate the reflecting team conversation by asking for their comments.

*Example 1*

2496 MW: just wonder what do you um any comments  
 2497 about those thoughts or reflections I know it  
 2498 was little distracting for you cause you were  
 2499 pretty [busy

Note: In contrast to more centered therapists who usually provide compliments from the team behind the one-way mirror or any other judgments based on their worldview and theoretical orientations, White asked clients to reflect on what resonated for them from the reflecting team conversation. In that way, he takes a decentered position. A more centered therapist might pick what resonated for him or her from a reflecting team conversation and would ask clients to reflect on those observations. I noticed that White did not do it.

**Non-hierarchical/Not-expert**

My conversation analysis shows that White not only avoids imposing his understanding about the consequences of the problems, but also avoids imposing his understanding about the consequences of the unique outcomes. Thus, he can be described as non-hierarchical or not-expert while performing a decentered position.

Supra-Themes	Themes
<u>NON-HIERARCHICAL/</u> <u>NOT-EXPERT</u> Therapist avoid imposing his understanding about the consequences not only problems but also unique outcomes. Therapist is taking a non-expert position and therefore creates non-hierarchical interaction with clients.	Therapist avoids imposing his understanding about the consequences of the unique outcomes.

**Therapist avoids imposing his understanding about the consequences of the unique outcomes.** White creates a non-hierarchical interaction by not knowing what are the consequences of unique outcomes. Instead, he asks the how evaluative questions.

*Example 1*

- 1721 MW: [yeah  
1722 How does that affect you? you know to be  
1723 more open in this way? How does it?=  
1724 D: = um I think (3.3) it makes me more um  
1725 (1.8) I don't know (.) it's it allows me  
1726 closer connections to people I think. =

Note: In this example, White is decentered by asking the question, “How does it affect you?” to be more open in this way (which is the unique outcome). A centered therapist would typically impose his understanding by, for example, giving her compliments for being more open. A centered therapist might also interpret her new openness as a reduction of her depressive symptoms that are caused by biochemical imbalance or due to a more positive and rational thinking. I noticed that White did not do it.

**White's Influential Position New Themes**

**Co-Researcher and Co-Creator of Context for Rich Story Development/ Narrative Metaphor**

As a co-researcher and co-creator of rich story development, White can be seen as influential by asking about and highlighting unique outcomes, by highlighting the effects of unique outcomes, and by writing down any reported changes or unique outcomes.

Supra-Themes	Themes
<u>CO-RESEARCHER AND CO-CREATOR</u> <u>OF CONTEXT FOR RICH STORY</u> <u>DEVELOPMENT/ NARRATIVE</u> <u>METAPHOR</u> Therapist is influential by co-creating a context for rich story development by asking about and highlighting unique outcomes, by highlighting the effects of unique outcomes and by writing down any reported changes or unique outcomes.	Therapist asks questions or highlights events outside of problem-saturated story or unique outcomes.  Therapist highlights the effects of unique outcomes reported by client on their lives.  Therapist writes down unique outcomes or any reported changes.

**Therapist asks questions or highlights events outside of problem-saturated story or unique outcomes.** In this example, White asks about her relationship with her husband and their teamwork in relation to children.

*Example 1*

- 712 D: = and we feel the same way about Andrew
- 713 and his care (.) we try to have a cooperative
- 714 spirit about =
- 715 MW: = right =
- 716 D: = about the kids and what they need
- 717 MW: okay so =
- 718 D: = so: =
- 719 MW: = and that teamwork survived survived the
- 720 separation? The teamwork
- 721 [in relation to children? =

- 722 D: [uh pretty good pretty good yeah I mean I  
 723 do most of the like 95 percent of the  
 724 research and I tell him what I found out and  
 725 but (.6) he certainly (.7) was very involved  
 726 with Andrew in the hospital when he was  
 727 there for the surgery =
- 728 MW: = yeah=
- 729 D: = we really that's been our primarily goal is  
 730 to keep that spirit in (tack)
- 731 MW: = \*keep that going\* =
- 732 D: = absolutely essential =

Note: In this example, White is influential by highlighting unique the outcome “and that teamwork survived separation?” Even though separation was difficult for the client, she said that they both had cooperative spirit and feel the same way about the children, and White highlighted that.

**Therapist highlights the effects of unique outcomes reported by client on their lives.**

In this example, the client was talking about how she was affected by her new increased openness and White paused and highlighted it by saying back what he heard.

*Example 1*

- 1724 D: = um I think (3.3) it makes me more um  
 1725 (1.8) I don't know (.) it's it allows me  
 1726 closer connections to people I think. =
- 1727 MW: = \*right\* (.) okay. So changes your quality

1728            of your [relationships =

1729    D:            [uh-huh

1730    MW: = with others =

1731    D:            = uh-huh =

Note: In this example, White highlights the effects of unique outcome by saying “right okay. So changes your quality of your relationships” and the client agrees with “uh-huh.”

**Therapist writes down unique outcomes or any reported changes.** During the session, White is taking notes of unique outcomes or/and the effects of unique outcomes. He is not taking notes of client’s problems, diagnoses, or his professional assessment of them; instead, he writes down the exact words and checks-in with the client. By writing down these specific things he is being influential.

*Example 1*

1410    D:            = ye:ah just kind of being (1.0) letting

1411            things just happen a lit more and not

1412            worrying so much about the consequences.

1413    MW: ((writing notes while she was talking))

Note: In this example, White writes down while the client was reporting the unique outcomes, “letting things just happen a lit more and not worrying so much about the consequences” which is a new development for her.

**Relational View of Identity/Social Construction**

White can be seen as influential by providing opportunities for clients to reflect on and evaluate the contributions of other people in development of their preferred identities and by asking family members if they have noticed any preferred changes,



which may contribute to thickening of client's preferred identity conclusion and is based on relational view of identity and social construction. This is based on a perspective that identities are social achievement created in relationships and through language.

Supra-Themes	Themes
<p><u>RELATIONAL VIEW OF IDENTITY/ SOCIAL CONSTRUCTION</u></p> <p>Therapist is influential by providing opportunities for clients to reflect on and evaluate the contributions of other people in development of their preferred identities and by asking family members if they have noticed any preferred changes, which may contribute to thickening of client's preferred identity conclusion and is based on relational view of identity and social construction. This is based on a perspective that identities are social achievement created in relationships and through language.</p>	<p>Therapist provides opportunities for client to reflect and experience preferred identity conclusion by asking if other people in client's life know or have noticed about their changes.</p> <p>Therapist provides opportunities for clients to reflect on and evaluate the contributions of other people in their lives on development of their preferred identity conclusion.</p> <p>Therapist asks question to family member which contributes to creating or/and thickening client's preferred identity conclusion.</p>

**Therapist provides opportunities for client to reflect and experience preferred identity conclusion by asking if other people in client's life know or have noticed about their changes.** In this example, White asks the client about her mother's comments about the changes she was making recently.

*Example 1*

- 1490 MW: = can you tell me about those comments? =
- 1491 D: = um (1.5) well that I am >you know< I've
- 1492 been much more relaxed about um (1.1)
- 1493 entertaining in my house like having family

1494            for dinner and having people over. It's

1495            much easier for me than it used to be. =

Note: In this example, White provided opportunity for the client to reflect on her mother's comments about her recent positive developments. That way, the client was able to experience and think about her preferred identity conclusion even more. White is thickening thin descriptions and contributes to rich story development about her preferred identity, which puts him in influential position.

**Therapist provides opportunities for clients to reflect on and evaluate the contributions of other people in their lives on development of their preferred identity conclusion.** In this example, White asks the client to reflect on contributions of her mother on construction of her preferred identity conclusion that includes her refusal to be so disciplined.

*Example 1*

2029    MW:    = So what is your mom said or done that's

2030            contributed to you (.5) this refusal to be so

2031            disciplined and some of the other things

2032            that we were talking about?

Note: It is evident that White does not see individuals creating and performing their identities in isolation. Instead, he is asking many questions that bring forth and thicken a client's preferred identity, including the contributions of other people to their lives, which make him influential. His relational view of identity is also based on social construction worldview.

**Therapist asks question to family member which contributes to creating or/and thickening client's preferred identity conclusion.** This means that White does not see people in isolation; rather he has a relational view of their identity conclusions.

*Example 1*

2180 MW: = before we turn around (.) just to get some  
 2181 (.3) we've been talking about things  
 2182 generally and some other questions that I  
 2183 would ask but I'm not going to because of  
 2184 the time situation I am interested in  
 2185 interviewing you about um (.9) a little bit  
 2186 more um (.3) because um Diane (.) is a little  
 2187 surprised that she is actually achieved what  
 2188 she has in terms of refusing to be so  
 2189 disciplined um reforming revising her  
 2190 relationship with hope challenging the  
 2191 expectations so that they don't stretch her  
 2192 (1.0) put her in a (limb) like they did and  
 2193 number of other developments. But I was  
 2194 gonna ask you whether you were surprised  
 2195 that she achieved this (.) and if you are  
 2196 surprised I would be interested in talking  
 2197 with you about that and if not I would be  
 2198 interested in you telling some story about

2199            your daughter that would give us a bit of an  
 2200            idea of what sort of foundations that she  
 2201            was standing on in order to make it a  
 2202            business to change the shape her life in a  
 2203            way that she has (.4) in recent times but (.7)  
 2204            I don't know if you have any immediate  
 2205            response to that?

Note: In this example, White is influential by being transparent about his intentions to interview mother about her daughter's achievements in terms of her refusing to be so disciplined, revising her relationship with hope, and challenging the expectations. He used editorial that included the client's language and interpretations. Then, White asked mother if she was surprised about her daughter's accomplishments, and if she could share a recent story about her daughter "that would give us a bit of an idea of what sort of foundations that she was standing on in order to make it." White engages mother in co-construction of her daughter's preferred identity by asking these questions and thus can be seen as having a relational view of identity based on social construction.

## **CHAPTER V: DISCUSSION**

The purpose of this study was to explore and better understand the performance of the decentered and influential position of the therapist in narrative therapy by studying Michael White's talk. This investigation addressed the research question: How, if at all, can White be seen to take a decentered and influential position in narrative therapy? In this chapter, I reflect upon the completed research by discussing my findings and some implications of the study. Additionally, I discuss future directions for research and some limitations of this study.

### **Discussion on Findings**

#### **White's Decentered Position**

In this video, my conversation analysis (CA) showed Michael White performing a decentered and influential stance in many different ways that are richly described in chapter 4. The decentered position is described as one in which White can be seen as a collaborative, egalitarian, non-hierarchical/non-expert, a non-pathologizing/poststructuralist, and curious. I learned from this session that performing the decentered position means creating interactions in which the therapist is a collaborator by privileging the client's voice, interpretations, meanings, skills, knowledge, and preferences, by paying close attention to client's language, and by asking and listening to what is important to clients.

In contrast to more centered therapists, who typically aim to identify and challenge clients' beliefs and irrational thoughts, for example cognitive and cognitive behavioral therapists (Beck et al., 1979; Ellis, 2005), or who try to transform the family system structure by using different interventions, such as marking boundaries, for

example structural therapists (Minuchin, 1974), this investigation showed Michael White performing a decentered position, which privileges the clients' beliefs, values, interpretations and preferences. For example, in this session White did not encourage the client to be more hopeful; rather, he was curious about her relationship with hope and her preference about it. By doing that, White privileges the client's voice, her meanings and interpretations, and her preferences. Thus, White does not collaborate with clients to set the stage for delivering interventions in order to convince them to change. Instead, by being decentered with clients, he collaborates with them throughout the entire session and respects their voices.

In this video, my CA showed that being decentered also means that the therapist is in an egalitarian interaction with clients by being transparent about the setting, about the process of therapy, about his experience of therapy and his intentions, by asking clients to evaluate the session and give their feedback, and by asking them to evaluate their problems, unique outcomes, and new developments around their identity conclusions. White (1995) believed that therapists have a moral and ethical responsibility when it comes to power differential between the therapist and the client. He said that "it is an error to believe that therapy can ever be totally egalitarian...[and]...that we should do what we can to make it very difficult for that power differential to have a toxic or negative effect" (White, 1995, p. 70). This suggests that narrative therapists should strive toward creating egalitarian relationships with clients and they should monitor their more powerful position. One way to do that is by being decentered. In this video, my CA showed that White was decentered in many different ways, for example, by being transparent, by asking evaluative questions, or by asking for

feedback, which puts him in an egalitarian interaction with his clients. Thus, being decentered makes him egalitarian as well.

In this study, I found that White's decentered position also means being in a non-hierarchical interaction with clients or being a non-expert. In this video, White accomplished that by respecting clients' meanings and understandings about their problems, by not knowing what is best for them and how they should live their lives, by not providing his expert knowledge and judgment in terms of compliments, solutions, insights, and normalizing. A more centered therapist, on the other hand, might provide compliments as in solution-focused therapy (de Shazer, 1985), or provide insights about clients' unfinished business from their childhood as in psychodynamic therapy (Freud, 1917), or give clients directives about how they should behave in order to solve their problems, as in Haley's strategic therapy (Haley, 1976), which puts the therapist in the expert position.

White refused to take such a position because he recognized the limits of "expert" knowledges that may lead to internalizing problems and objectification of identity (White, 2007). Many of the problems that people struggle with, White (2007) believed, are cultural in nature. This means that people are measuring and evaluating their lives, relationships, and identities based on the dominant cultural ideals and stories that include what it means to be a "real" person, or to be successful, or to have a good relationship, and so forth. They evaluate themselves based on whether they are matching that culturally created or "normal" standard. If the person is not matching these standards, his or her negative self-evaluations are likely to produce feelings of inadequacy and deficiency and perceptions of oneself as being dysfunctional and disordered.

It was evident in this session that White refused to act as an expert or a social engineer by taking a decentered position. According to my CA, White can be seen as decentered and non-hierarchical by not trying to “fix” people into becoming normal, and by not imposing his understanding about the consequences of the unique outcomes. I found that being decentered means that the client’s voice and knowledge are privileged because they are seen as experts on their lives.

In this video, my CA showed that White’s decentered stance means having a non-pathologizing and post-structural view, in which therapist tends not to objectify and categorize people, and to see them in totalizing ways, because he is not seeing them as having internal structures that need to be “fixed” into becoming less pathological or normal. White performed the decentered position when he avoided reproducing dominant discourse, and he saw his clients as acting according to their intentions, beliefs, values, goals, aspirations, and dreams. During the session, he asked the clients many questions about their hopes and aspirations. White did not diagnose the clients with depression, eating disorder, ADHD, and so forth. The non-pathologizing view of people in a decentered stance allows White to create a context for collaboration and non-hierarchical relationship. In this session, my CA analysis showed that White performs the decentered position with lots of curiosity given that he mostly asked questions, and he avoided making statements and giving the advice.

### **White’s Influential Position**

According to my CA, while performing the influential position White can be seen as a co-researcher and co-creator of context for rich story development and preferred identity conclusion and as a creator of context for reflection, discovery, learning, and



personal agency. It is also evident that influential stance is shaped by the relational view of identity, social construction, narrative metaphor, and post-structuralism.

In this session as a co-researcher and co-creator of context for rich story development, White is influential by providing opportunities for clients to deconstruct their dominant story, to more richly describe alternative stories, and to step into and explore some neglected territories of their lives. During the session, White was curious about how the client refused to live under the expectations that she must be perfect and how she refused to be so self-disciplined and became more open with other people. My CA showed that White assisted clients in rich story development by asking about and highlighting the unique outcomes and by writing down any reported changes and unique outcomes. Thus, I believe that learning how to listen for the unique outcomes is the essential first step for the influential stance in narrative therapy. Once the therapist hears the unique outcome, the alternative and more preferred stories can be co-created if the therapist is curious and asks questions about it. White performed influential stance by asking many questions about the client's unique outcomes during this session. He highlighted them and wrote them down for his future questions and editorials. It is important to note that White did not perform the influential stance by intervening to fix the "dysfunctional" family system; instead, he was influential by being curious about clients' hopes, dreams, and aspirations and by thickening alternative story which was evident throughout this session.

My CA of this video showed that White's influential stance also served in creating a context for co-construction of the preferred identity conclusions. I found that White is influential by creating a context in which clients have opportunities for re-

experiencing their identity and creating a more preferred identity conclusion. During this session, White provided many opportunities for the client to separate herself from the problem and to experience her preferred identity conclusion (e.g., as being more open, as having a sense of accomplishment, as being less perfect, etc.).

Being influential in this way is based on White's post-structuralist perspective that suggests seeing people in relationship with ideas rather than in possession of internal psychological structures or "selves." In this video, my CA showed that White is influential by objectifying the client's problems (e.g., "this fear," "perfection," etc.) and by asking the clients about their hopes, dreams, aspirations, intentions, and preferences. By taking the influential stance, White created opportunities for the client to revise her relationship with the problem (e.g., hope, perfection, discipline) and as a result to experience her preferred identity. I also learned that in influential stance, White assisted clients to move from what is known and familiar to what might be possible for the client to know about his or her life and identity.

This investigation showed that as a creator of context for reflection, discovery, learning and personal agency, White can be seen as being influential in this video by providing opportunities for clients to become more acquainted with knowledges and skills of their lives that are relevant in addressing their concerns, by asking questions that open possibilities for them to pursue what they value and hold precious, by not imposing his agenda and delivering interventions, and by not asking questions that lead to known knowledge. White was not influential by providing his expert knowledge; rather, he was curious about the client's values, and preferences and that co-investigation or co-research led to new discoveries, realizations, and personal agency.

My CA of this session also suggests that White has a relational view of clients' identity conclusions (which is based on social constructionism) while taking the influential stance. White was influential by providing opportunities for the clients to reflect on and to evaluate the contributions of other people in the co-construction of their preferred identities, and by asking family members if they have noticed any preferred changes, which may, in turn, lead to thickening the client's preferred identity conclusion. From his performance of the influential position, it can be concluded that White sees people's identities as a social achievement, created in relationships and through language.

In conclusion, my CA showed that White takes the decentered and influential position in this session, and I described many ways that he performs it. This study not only provides validation for the presence of the influential and decentered therapist positions in White's narrative therapy practice, but also expands the knowledge of ways in which he accomplishes this.

### **White's Decentered and Influential Position**

Even though, for the purposes of this study, the decentered and influential positions are separated, in order to gain more understanding of these concepts and to richly describe ways in which White takes a decentered stance and influential stance, they can also be seen as connected. Using Flemons's (1991) completing distinctions ideas, the relationship between the decentered and influential positions can be described as separated but also connected, and therefore represented in the following way:

#### **THE POSITION OF THE THERAPIST / (Decentered / Influential)**

Throughout this session, White can be seen and described as being decentered and influential at the same time. For example, when he asked the client to evaluate her

unique outcomes, which positions him as decentered and egalitarian, White also provided the opportunity for the client to richly describe her alternative story, which situates him as influential and a co-creator of context for rich story development. Thus, he can be seen as simultaneously decentered and influential.

White can also be seen as being influential in a decentered way. For example, White was influential by providing opportunities for the client to create a more preferred identity conclusion by using editorials, in which he also privileged the client's voice and preferences about who she wants to be. In this way he is both decentered and collaborative. Therefore, it is possible to describe White as being influential in a decentered way. In conclusion, White can be seen as taking the decentered position, the influential position, and both decentered and influential position because they are often combined.

### **Humor and Empathy**

During my conversation analysis, I also noticed some additional aspects of White's discourse that were not the focus of this study. I discovered that White shows that he cares and shows empathy. For example, White asked the client about her son, "Can he look forward to being free from surgery from this point on?" In this question, he demonstrated that he cares and is curious about the client's pain-free future given that the mother described how painful it was for her son to go through surgery.

I also observed that White uses humor throughout the session. For instance, he said at the beginning of the session that he was still recovering from his trip and that, "if I ask the same question twice you know that=" which made the client laugh and respond, "it's okay...I'll answer the same question twice." He also used humor in an awkward

situation such as when he accidentally spilled his water, he said, “I am blaming it on jet leg.”

I noticed that throughout the session, the client and the therapist often laughed together which could be interpreted as a sign of a positive relationship and as White being emotionally in sync with the client. In addition, I observed that when White was interrupted, he let the client talk. Even though these findings were not the focus and the goal of my study, they can serve as useful information about some additional aspects of White’s discourse that can be studied in more details in future studies.

### **Findings and Previous Studies**

In contrast to Gale’s (1991) study which focused on patterns and discovering procedures of how the therapist elicits solution-oriented talk from the client, this study used CA to focus on describing ways in which White can be seen to take a decentered and influential stance, without examining the effects of this stance on the client’s talk. Thus, compared to more traditional studies using conversation analysis, this study did not focus on how the therapist and the client switch turns, or on their overlap in the talk, or some paralinguistic features of talk.

Conversation analysis was used in this study to richly describe White’s performance of decentered and influential position and focus was on his talk. In contrast to Kogan and Gale’s (1997) study that describes White’s agenda as “decentering,” and focuses on how “decentering agenda” is accomplished with a couple at the conference setting, this study utilized White’s (2005) model of position of the therapist in narrative therapy to explore how White takes a decentered and influential stance. It is important to note that Kogan and Gale’s definition of “decentering” is not the same as what White

described in his literature on decentered and influential position of the therapist, which was used for the purposes of this study.

### **Implications**

The findings of this study can be used as a template for practicing and training narrative therapists how to perform the decentered and influential stance. Narrative therapists can use these findings to improve their clinical practice and to create decentered but influential relationships with their clients. Given the limited amount of literature about this stance, narrative therapists can use the findings of this study to better understand the concept of the decentered and influential and to learn how Michael White used it in many different ways in his consultation with this family. The findings of this study can also be used as a tool in narrative therapy supervision and self-supervision to increase therapists' awareness of their stance, and whether they are performing the decentered and influential position, which may lead to improving their relational clinical skills and creating and maintaining the positive relationships with the clients.

The findings of this study also suggest consistency between White's writings and his performance. I was able to observe him performing decentered and influential stance most of the time throughout the session even though there are few instances where he could be categorized as more centered (e.g., when he complimented the child for good behavior during the session). In addition, while some new themes emerged from my data analysis, some themes from my inclusion criteria, which were based on literature review, were not found. Thus, it can be concluded that White does not perform all these themes in every session while being decentered and influential.

Most of the time throughout the session White used questions and avoided making statements that include his insights and suggestions while being decentered and influential. It could be valuable information for some students to learn that even Master therapists such as Michael White are not perfect in their performances. Thus, learning how to be decentered and influential takes time and practice.

By focusing on the performance of the therapist, this study provides a better understanding of how different concepts or ideas are applied in therapy. I believe that successful performance of any model of therapy requires not only theoretical knowledge of its concepts but also applied understanding how it is done. Many students report that they have theoretical knowledge about narrative practices, but they have difficulty applying them. The findings of this study could help them in that regard, as it helped me to better understand the decentered and influential position and how to apply it in my clinical practice.

Also, instructors who teach narrative therapy courses can use these findings for their presentations and explanation of White's decentered and influential stance in narrative therapy.

### **Limitations and Future Studies**

Limitations of the present study must be noted and considered in future research. First, only a single-session case was analyzed using conversation analysis. Replication of this study that includes other cases would improve validity of my findings and contribute to more generalization of my findings. Although narrative therapy does not claim to treat different races, gender, ethnic groups or problems differently, it would be interesting to compare findings from this study with other case studies that include more diverse

population, not only families but also couples and individuals, cases that include more sessions not only one, and different presenting problems. Thus, it is recommended to replicate this study using more diverse cases.

Second, this study is limited by the use of a researcher as an instrument of inquiry. Given that the researcher is the instrument of the study in conversation analysis, my claims are my interpretation and are subject to readers' analysis. I provided for readers the examples from the transcript to evaluate each theme and to make their conclusions. The consumers of this research also have the opportunity to make their own interpretations based on the entire transcript listed in appendix C. It is likely that each reader of this study "brings her or his own world view/epistemology that will organize how she or he makes sense of what is written" (Gale, 1991, p. xi). Furthermore, to address this limitation I met with my dissertation chair, Dr. Hibel, who challenged my interpretations and helped me become more reflexive in the process of study. I approached this study with open mind and discovery oriented attitude. I do not claim that my findings are facts and static. I recommend that future studies include research team to conduct data analysis where subjectivity is addressed by coming to the consensus on the interpretations of the findings (Hays & Singh, 2012). Prospective studies can investigate additional ways how narrative therapists can be seen as decentered and influential in narrative therapy.

Third, this study did not focus on patterns and sequences of talk between the therapist and the client. Instead, the focus was mainly on Michael White's talk in order to richly describe and better understand his decentered and influential position. Consequently, this study did not provide information about how taking a decentered and



influential stance affects the relationship between the therapist and the client or/and how it affects the outcome of therapy. However, given that this study provides rich information about the decentered and influential stance this study can be seen as a steppingstone for future studies that focus on answering such research questions using different research methods. For example, quantitative studies can be used to explore the impact of decentered and influential stance on the therapist's well-being, burnout, satisfaction, and compassion fatigue. Quantitative studies can be used to investigate the correlation between the decentered and influential stance and client's perception of therapeutic alliance and the outcome of therapy. If future studies discover positive effects of this stance, marriage and family therapists could use these findings to improve their chances of providing treatment that includes the highest likelihood of success and the greatest benefits for both clients and therapists.

It is important to recognize that this study did not investigate the effects of decentered and influential stance on the client-therapist relationship. However, it is reasonable to expect and assume that the stance of the therapist affects the interaction if we believe in interconnectedness and that our thoughts and actions are connected.

Previous research has indicated that a relationship between the therapist and the client is an important factor in a successful outcome of therapy (see review in Chapter 2). Among many factors that could influence and shape the relationship between the therapist and the client, the position of the therapist in that relationship is rarely studied. This study was the first step in that direction by exploring and explaining how, if at all, White can be seen to take a decentered and influential stance in narrative therapy.

Based on my observation, I believe that White's decentered and influential stance contributed to creating positive relationships with his clients. Also, given that a narrative therapist's stance is described as decentered and influential (White, 2007), we could say that narrative therapists tend to co-create with clients decentered and influential therapeutic relationships.

I also believe that the decentered and influential stance should not be practiced as a technique, but rather it should be seen and adopted as a way of being with clients in narrative therapy, because it is based on a specific worldview which includes post-structuralism, narrative metaphor, social construction, relational view of identity, Foucault's modern power and so on (see review in chapter 2). I believe that unless the therapist adopts this worldview, it would be difficult or impossible for him or her to perform this stance.

### **Personal Reflection on Conversation Analysis**

Conducting a conversation analysis was a long process that required a great attention to details. I recommend to future researchers using conversation analysis to first watch and listen to very short segments (few seconds long) of a session while transcribing, and then to repeat, watching longer segments to check for accuracy of their transcribing and analysis. While practicing conversation analysis, it is possible that researchers are developing their attention to detail skill, which is a useful tool not only for the research purposes, but also it can improve their communication and listening skills in therapy session by learning to pay close attention to details. Conversation analysis was a useful method for this study because it provided findings of White's decentered and influential position that are rich in details.

## References

- Adler, A. (1924). *The practice and theory of Individual Psychology*. Routledge, Trench, Trubner & Co, Ltd.
- Adler, A. (1964). *Problems of neurosis*. Oxford, England: Harper Torchbooks.
- Anderson, H., & Goolishian, H. A. (1988). Human systems as linguistic systems: Preliminary and evolving ideas about the implications for clinical theory. *Family Process*, 27(4), 371-393.
- Anderson, H., & Goolishian, H. (1992). The client is the expert: A not-knowing approach to therapy. In S. McNamee & K. J. Gergen (Eds.), *Therapy as social construction* (pp. 25-40). London, England: Sage.
- Arnow, B. A., Steidtmann, D., Blasey, C., Manber, R., Constantino, M. J., Klein, D. N., ...Kocsis, J. H. (2013). The relationship between the therapeutic alliance and treatment outcome in two distinct psychotherapies for chronic depression. *Journal of Consulting and Clinical Psychology*, 81(4), 627-638. doi: 10.1037/a0031530
- Baker, K. G. (2014). A long-term coaching process: Differentiation for client and coach. In P. Titelman (Ed.), *Differentiation of self: Bowen family systems theory perspectives* (pp. 219-238). New York, NY: Taylor & Francis.
- Bateson, G. (1972). *Steps to an ecology of mind*. Chicago: University of Chicago Press.
- Bauer, G. P. (1994). *Essential papers on transference analysis*. Northvale, NJ: Aronson.
- Beck, A. T. (1979). *Cognitive therapy and the emotional disorders*. New York, NY: Meridian.
- Beck, J. S. (1995). *Cognitive therapy: Basics and Beyond*. New York, NY: The Guilford Press.

- Beck, A. T., Rush, J. A., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York, NY: The Guilford Press.
- Becvar, D. S., & Becvar, R. J. (1999). *Systems theory and family therapy* (2<sup>nd</sup> ed.). New York, NY: University Press of America.
- Becvar, D. S., & Becvar, R. J. (2006). *Family therapy: A systemic integration* (6<sup>th</sup> ed.). Boston, MA: Pearson Education.
- Bedi, R. P., Davis, M. D., & Williams, M. (2005). Critical incidents in the formation of the therapeutic alliance from the client's perspective. *Psychotherapy: Theory, Research, Practice, Training*, 42(3), 311–323. doi: 10.1037/0033-3204.42.3.311
- Berg, I. K., & Dolan, Y. (2001). *Tales of solutions: A collection of hope-inspiring stories*. New York, NY: W. W. Norton.
- Bitter, J. R., & Nicoll, W. G. (2000). *Adlerian brief therapy with individuals: Process and practice*. Retrieved from [http://c2.buncombe.schoolwires.net/cms/lib5/NC01000308/Centricity/ModuleInstance/11449/Handouts\\_\\_Adlerian\\_Brief\\_Therapy\\_with\\_Individuals.pdf](http://c2.buncombe.schoolwires.net/cms/lib5/NC01000308/Centricity/ModuleInstance/11449/Handouts__Adlerian_Brief_Therapy_with_Individuals.pdf)
- Boscolo, L., Cecchin, G., Hoffman, L., & Penn, P. (1987). *Milan systemic family therapy: Conversations in theory and practice*. New York, NY: Basic Books.
- Boszormenyi-Nagy, I., & Krasner, B. R. (1986). *Between give and take: A clinical guide to contextual therapy*. New York, NY: Brunner/Mazel.
- Bourgeois, L., Sabourin, S., & Wright, J. (1990). Predictive validity of therapeutic alliance in group marital therapy. *Journal of Consulting and Clinical Psychology*, 58, 608–613.

- Brown, P. D., & O'Leary, K. D. (2000). Therapeutic alliance: Predicting continuance and success in group treatment for spouse abuse. *Journal of Consulting and Clinical Psychology, 68*, 340–345.
- Bruner, J. (2004). The narrative creation of self. In L. E. Angus & J. McLeod (Eds.), *The handbook of narrative psychotherapy: Practice, theory, and research* (pp. 3-14). Thousand Oaks, CA: Sage.
- Burnett, C. F. (2013). Bowen family systems therapy. In A. Rambo, C. West, A. Schooley, T. Boyd (Eds.), *Family therapy review: Contrasting contemporary models* (pp. 67-71). New York, NY: Taylor & Francis.
- Carey, M., Walther, S., & Russell, S. (2009). The absent but implicit: A map to support therapeutic enquiry. *Family Process, 48*(3), 319-331.
- Corey, G. (2005). *Theory and practice of counseling and psychotherapy* (7<sup>th</sup> ed.). Belmont, CA: Thomson Learning.
- Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2<sup>nd</sup> ed.). Thousand Oaks, CA: Sage.
- de Shazer, S. (1985). *Keys to solution in brief therapy*. New York, NY: W. W. Norton.
- de Shazer, S., Dolan, Y., Korman, H., Trepper, T., McCollum, E., & Berg, I. K. (2007). *More than miracles: The state of the art of solution-focused brief therapy*. New York, NY: Routledge.
- Dollard, J., & Miller, N. E. (1950). *Personality and psychotherapy: An analysis in terms of learning, thinking, and culture*. New York, NY: McGraw-Hill.
- Duvall, J., & Beres, L. (2011). *Innovations in narrative therapy: Connecting practice, training, and research*. New York, NY: W. W. Norton.

- Ellis, A. (1976). RET abolishes most of the human ego. *Psychotherapy: Theory, Research and Practice*, 13(4), 343-348.
- Ellis, A. (2003). Early theories and practices of rational emotive behavior therapy and how they have been augmented and revised during the last three decades. *Journal of Rational-Emotive & Cognitive-Behavior Therapy*, 21(3), 219-243.
- Ellis, A. (2005). *The myth of self-esteem*. Amherst, NY: Prometheus.
- Ellis, A. (2011). Rational emotive behavior therapy. In R. J. Corsini & D. Wedding (Eds.), *Current psychotherapies* (9<sup>th</sup> ed.) (pp. 196-235). Belmont, CA: Cengage Learning: Brooks/Cole.
- Fenichel, O. (1972). *The psychoanalytic theory of neurosis*. New York, NY: W. W. Norton.
- Fillingham, L. (1993). *Foucault for beginners*. New York, NY: Writers and Readers.
- Fisch, R., Weakland, J. H., & Segal, L. (1982). *The tactics of change*. San Francisco, CA: Jossey-Bass.
- Flemons, D. G. (1991). *Completing distinctions*. Boston, MA: Shambhala.
- Foucault, M. (1971). Debate Noam Chomsky & Michel Foucault: On human nature. Retrieved from, <https://www.youtube.com/watch?v=3wfNl2L0Gf8>
- Freedman, J., & Combs, G. (1996). *Narrative therapy: The social construction of preferred realities*. New York, NY: W. W. Norton.
- Freud, S. (1917). Lecture XXVII: Transference. In J. Strachey (Ed.), *Introductory lectures on psychoanalysis* (pp. 431-447). New York, NY: W. W. Norton.
- Freud (1912). The dynamics of the transference (1912). In *Sigmund Freud: Therapy and Technique* (pp. 105-115). New York, NY: Collier Books.

- Friedman, H. S., & Schustack, M. W. (2003). *Personality: Classic theories and modern research* (2<sup>nd</sup> ed.). Boston, MA: Allyn and Bacon.
- Gale, J. E. (1991). *Conversation analysis of therapeutic discourse: The pursuit of a therapeutic agenda*. Norwood, NJ: Ablex.
- Gale, J. (1996). Conversation analysis: Studying the construction of therapeutic realities. In D. H. Sprenkle & S. M. Moon (Eds.), *Research methods in family therapy* (pp. 107-124). New York, NY: The Guilford Press.
- Gale, J., & Newfield, N. (1992). A conversation analysis of a solution-focused marital therapy session. *Journal of Marital and Family Therapy*, 18(2), 153-165.
- Gaston, L. (1990). The concept of the alliance and its role in psychotherapy: Theoretical and empirical considerations. *Psychotherapy*, 27(2), 143-153.
- Gergen, K. (2009). *An invitation to social construction* (2<sup>nd</sup> edition). Sage Publications.
- Goldenthal, P. (1993). *Contextual family therapy: Assessment and intervention procedures*. Sarasota, FL: Professional Resource Press.
- Golafshani, N. (2003). Understanding reliability and validity in qualitative research. *The Qualitative Report*, 8(4), 597-606. Retrieved from <http://nsuworks.nova.edu/tqr/vol8/iss4/6>
- Goolishian, H. A., & Winderman, L. (1988). Constructivism, autopoiesis and problem determined systems. *The Irish Journal of Psychology*, 9(1), 130-143.
- Haley, J. (1976). *Problem-solving therapy: New strategies for effective family therapy*. San Francisco, CA: Jossey-Bass.
- Haley, J. (1980). *Leaving home: The therapy of disturbed young people*. New York, NY: McGraw-Hill.

- Hare-Mustin, R. T. (1978). A feminist approach to family therapy. *Family Process*, 17, 181-194.
- Hays, D. G., & Singh, A. A. (2012). *Qualitative inquiry in clinical and educational settings*. New York, NY: The Guilford Press.
- Heritage, J. (1984). *Garfinkel and Ethnomethodology*. Cambridge, England: Polity Press.
- Hoffman, L. (1992). Constructing the theoretical context: A reflexive stance for family therapy. In S. McNamee & K. J. Gergen (Eds.), *Therapy as social construction* (pp. 7-25). London, England: Sage.
- Hoffman, L. (2002). *Family therapy: An intimate history*. New York, NY: W. W. Norton.
- Horvath, A. O. (2001). The therapeutic alliance: Concepts, research and training. *Australian Psychologist*, 36(2), 170-176.
- Horvath, A. O., & Symonds, B. D. (1991). Relation between the working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology*, 38, 139-149.
- Hutchby, I., & Wooffitt, R. (1998). *Conversation analysis: Principles, practices, and applications*. Cambridge, England: Polity Press.
- Hutchby, I., & Wooffitt, R. (2008). *Conversation analysis (2<sup>nd</sup> ed.)*. Cambridge, England: Polity Press.
- Johnson, S. M. (2004). *The practice of emotionally focused couple therapy (2<sup>nd</sup> ed.): Creating connection*. New York, NY: Brunner-Routledge.
- Johnson, S. M. (2008). Emotionally focused couple therapy. In A. S. Gurman (Ed.), *Clinical handbook of couple therapy (4<sup>th</sup> ed.)* (pp. 107-137). New York, NY: The Guilford Press.



- Johnson, S. M., & Talitman, E. (1997). Predictors of success in emotionally focused marital therapy. *Journal of Marital and Family Therapy*, 23(2), 135- 152.
- Johnson, L., & Ketrings, S. (2006). The therapy alliance: A moderator in therapy outcome for families dealing with child abuse and neglect. *Journal of Marital and Family Therapy*, 32, 345–354.
- Johnson, L. N., Wright, D. W., & Ketrings, S. A. (2002). The therapeutic alliance in home-based family therapy: Is it predictive of outcome? *Journal of Marital and Family Therapy*, 28, 93–102.
- Kazdin, A. E., Marciano, P. L., & Whitley, M. K. (2005). The therapeutic alliance in cognitive-behavioral treatment of children referred for oppositional, aggressive, and antisocial behavior. *Journal of Consulting and Clinical Psychology*, 73, 726–730.
- Kepner, E. (1980). *Gestalt group process*. Retrieved from <http://www.elementsuk.com/libraryofarticles/gestalt.pdf>
- Kerr, M. E. (1984). Theoretical base for differentiation of self in one's family of origin. In C. Munson (Ed.), *Family of origin clinical supervision* (pp. 3-35). New York, NY: The Howard Press.
- Kerr, M. E., & Bowen, M. (1988). *Family evaluation: An approach based on Bowen theory*. New York, NY: W.W. Norton.
- Knobloch-Fedders, L. M., Pinsof, W. M., & Mann, B. J. (2007). Therapeutic alliance and treatment progress in couple psychotherapy. *Journal of Marital and Family Therapy*, 33, 245–257.

- Kogan, S. M., & Gale, J. E. (1997). Decentering therapy: Textual analysis of a narrative therapy session. *Family Process*, 36(2), 101-126.
- Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, Research, Practice, Training*, 38(4), 357-361.
- Maisel, R., Epston, D., & Borden, A. (2004). *Biting the hand that starves you: Inspiring resistance to anorexia/bulimia*. New York, NY: W. W. Norton.
- Manaster, G. J., & Corsini, R. J. (2009). *Individual psychology: Theory and practice*. Adler School of Professional Psychology.
- Mangold, R. (2013). *Adler: Individual psychology*. Retrieved from [https://www.ivcc.edu/uploadedFiles/\\_faculty/\\_mangold/Adler-%20Individual%20Psychology.pdf](https://www.ivcc.edu/uploadedFiles/_faculty/_mangold/Adler-%20Individual%20Psychology.pdf)
- Martin, D. J., Garske, J. P., & Davis, K. M. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, 68, 438–450.
- Mitchell, S. A., & Black, M. J. (1995). *Freud and beyond: A history of modern psychodynamic thought*. New York, NY: Basic Books.
- Minuchin, S. (1974). *Families and family therapy*. Massachusetts: Harvard University Press.
- Minuchin, S., & Nichols, M. P. (1993). *Family healing: Tales of hope and renewal from family therapy*. New York, NY: The Free Press.
- MohdZain, Z. A. (2001). Feminist family therapy and the male perspective. In K. M. May (Ed.), *Feminist family therapy*, (pp. 53- 67). Alexandria, VA: American Counseling Association.

- Myerhoff, B. (1982). Life history among the elderly: Performance, visibility, and remembering. In J. Ruby (ED.), *A crack in the mirror: Reflexive perspective in anthropology* (pp. 231 – 347). Philadelphia: University of Pennsylvania Press.
- Parry, A., & Doan, R. E. (1994). *Story re-visions: Narrative therapy in the postmodern world*. New York, NY: The Guilford Press.
- Perakyla, A. (2007). Conversation analysis. In C. Seale, G. Gobo, J. F. Gubrium, & D. Silverman (Eds.), *Qualitative research practice*, (pp. 153-167). London, England: Sage.
- Perakyla, A., Antaki, C., Vehvilainen, S., & Leudar, I. (2008). *Conversation analysis and psychotherapy*. Cambridge: Cambridge University Press.
- Perls, L. (1976). Comments on new directions. In E. W. L. Smith (Ed.), *The growing edge of Gestalt therapy* (pp. 221-226). New York, NY: Brunner/Mazel.
- Poster, M. (1989). *Critical theory and poststructuralism: In search of a context*. Ithaca: Cornell University Press.
- Raytek, H. S., McCrady, B. S., Epstein, E. E., & Hirsch, L. S. (1999). Therapeutic alliance and the retention of couples in conjoint alcoholism treatment. *Addictive Behaviors*, 24, 317–330.
- Robbins, M. S., Turner, C. W., Alexander, J. F., & Perez, G. A. (2003). Alliance and dropout in family therapy for adolescents with behavior problems: individual and systemic effects. *Journal of Family Psychology*, 17, 534–544.
- Robbins, M. S., Liddle, H. A., Turner, C. W., Dakof, G. A., Alexander, J. F., & Kogan, S. M. (2006). Adolescent and parent therapeutic alliances as predictors of dropout in multidimensional family therapy. *Journal of Family Psychology*, 20, 108–116.

- Robins, M. S., Mayorga, C. C., Mitrani, V. B., Szapocznik, J., Turner, C. W., & Alexanser, J. F. (2008). Adolescent and parent alliances with therapists in brief strategic family therapy with drug-using Hispanic adolescents. *Journal of Marital and Family Therapy*, 34(3), 316-328.
- Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21(2), 95-103.
- Rosenau, P. M. (1992). *Post-modernism and the social sciences*. Princeton, NJ: Princeton University Press.
- Satir, V. (1967). *Conjoint family therapy (revised edition)*. Palo Alto, CA: Science and Behavior Books.
- Satir, V. (1975). You as a change agent. In V. Satir, J. Stachowiak, & H. A. Taschman (Eds.), *Helping families to change* (pp. 37-64). New York, NY: Jason Aronson.
- Satir, V. (1975). Intervention for congruence. In V. Satir, J. Stachowiak, & H. A. Taschman (Eds.), *Helping families to change* (pp. 79-105). New York, NY: Jason Aronson.
- Scharff, D. E., & Scharff, J. S. (1987). *Object relations family therapy*. London, England: Jason Aronson.
- Seem, S. R. (2001). Feminist family therapy: For heterosexual couples and families only? In K. M. May (Ed.), *Feminist family therapy*, (pp. 29-53). Alexandria, VA: American Counseling Association.
- Sharf, J., Primavera, L. H., Diener, M. J. (2010). Dropout and therapeutic alliance: A meta-analysis of adult individual psychotherapy. *Psychotherapy Theory*,

- Research, Practice, Training*, 47(4), 637-645. doi: 10.1037/a0021175
- Shelef, K., Diamond, G. M., Diamond, G. S., & Liddle, H. A. (2005). Adolescent and parent alliance and treatment outcome in multidimensional family therapy. *Journal of Consulting and Clinical Psychology*, 73, 689–698.
- Silverstein, L. B. (2003). Classic texts and early critiques. In L.B. Silverstein & T. J. Goodrich (Eds.), *Feminist family therapy: Empowerment in social context* (pp. 17-37). Washington, DC: American Psychological Association.
- Skinner, B. F. (1953). *Science and human behavior*. New York, NY: The Free Press.
- Selvini-Palazzoli, M., Boscolo, L., Cecchin, G., & Prata, G. (1980). Hypothesizing, circularity, neutrality: Three guidelines for the conductor of the session. *Family Process*, 19, 3-12.
- Stake, R. E. (1995). *The art of case study research*. Thousand Oaks, CA: Sage.
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2<sup>nd</sup> ed.). Thousand Oaks, CA: Sage.
- ten Have, P. (2007). Ethnomethodology. In C. Seale, G. Gobo, J. F. Gubrium, & D. Silverman (Eds.), *Qualitative research practice*, (pp. 139-152). London, England: Sage.
- von Foerster, H. (1973). *On constructing a reality*. Lecture, Virginia Polytechnic Institute: Virginia, US.
- Walters, M., Carter, B., Papp, P., & Silverstein, O. (1988). *The invisible web: Gender patterns in family relationships*. New York, NY: The Guilford Press.
- Watzlawick, P., Beavin, J., & Jackson, D. (1967). *Pragmatics of human communication*. New York, NY: W. W. Norton.

- Wickman, S. A., & Campbell, C. (2003). An analysis of how Carl Rogers enacted client-centered conversation with Gloria. *Journal of Counseling and Development*, 81(2), 178-184.
- Whitaker, C. A., & Bumberry, W. M. (1988). *Dancing with the family: A symbolic-experiential approach*. New York, NY: Brunner/Mazel.
- White, M. (1986a). Negative explanation, restraint, & double description: A template for family therapy. *Family Process*, 25(2), 85-99.
- White, M. (1986b). Transcript from Michael White video session. Unpublished.
- White, M. (1989). The externalizing of the problem and re-authoring of lives and relationships. In M. White (Ed.), *Selected papers* (pp. 5-29). Adelaide, Australia: Dulwich Centre Publications.
- White, M. (1992). Deconstruction and therapy. In D. Epston, & M. White, M. (Eds.), *Experience, contradiction, narrative and imagination: Selected papers of David Epston & Michael White* (pp. 109 – 151). Adelaide, Australia: Dulwich Centre Publications.
- White, M. (1993). Commentary: The histories of the present. In S. Gilligan, & R. Price (Eds.), *Therapeutic conversations* (pp. 121-135). New York, NY: W. W. Norton.
- White, M. (1995). *Re-authoring lives: Interviews & essays*. Adelaide, Australia: Dulwich Centre Publications.
- White, M. (1997). *Narratives of therapists' lives*. Adelaide, Australia: Dulwich Center Publications.
- White, M. (2002). Addressing personal failure. *The International Journal of Narrative Therapy and Community Work*, 3, 33-70.

- White, M. (2003). Narrative practice and community assignments. *The International Journal of Narrative Therapy and Community Work*, 2, 17-55.
- White, M. (2004). Folk psychology and narrative practices. In L. E. Angus, & J. McLeod (Eds.), *The handbook of narrative and psychotherapy: Practice, theory, and research* (pp. 15-53). Thousand Oaks, CA: Sage.
- White, M. (2005). Michael White workshop notes. Retrieved from, [www.dulwichcentre.com.au](http://www.dulwichcentre.com.au)
- White, M. (2007). *Maps of narrative practice*. New York, NY: W. W. Norton.
- White, M. (2011). *Narrative practice: Continuing conversations*. New York, NY: W. W. Norton.
- White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York, NY: W. W. Norton.
- Young, M. A. (2008). Attachment theory's focus in EFT: An interview with Susan Johnson. *The Family Journal: Counseling and Therapy for Couples and Families*, 16(3), 264-270. doi: 10.1177/1066480708317673

## **Appendices**



Appendix A  
Inclusion Criteria

## Inclusion Criteria

### **Part A: Decentered Position**

1. Therapist privileges client's voice.
2. Therapist privileges client's interpretations.
3. Therapist privileges client's meanings.
4. Therapist privileges clients' skills and knowledges.
5. Therapist privileges clients' preferences.
6. Therapist asks clients to evaluate problems.
7. Therapist pays close attention to client's language.
8. Therapist sees clients as acting according to their intentions, values, beliefs, hopes, dreams, aspirations, and/or goals.
9. Therapist challenges certainties.
10. Therapist seems to listen to what is important to client.
11. Therapist asks what is important for client.
12. Therapist seems to collaborate with clients.
13. Therapist mostly asks questions.
14. Therapist seems to be transparent.
15. Therapist invites clients to evaluate session.
16. Therapist asks for client's feedback.
17. Therapist seems to create egalitarian relationship with clients.
18. Therapist avoids simplistic behavioral goals.
19. Therapist refrains from attributing meaning to client's problems.

20. Therapist avoids imposing his understanding about the consequences of the problems.
21. Therapist does not act as a primary author in how clients should live their lives.
22. Therapist avoids prescribing directions for client.
23. Therapist holds back knowing in advance what is best for the client.
24. Therapist avoids providing diagnosis for client's problems and avoids objectifying the client.
25. Therapist avoids providing solutions for client.
26. Therapist refrains from providing normalizing judgment.
27. Therapist avoids providing compliments.
28. Therapist avoids confronting clients about their beliefs.
29. Therapist refrains from seeking to discover the truth.
30. Therapist avoids providing his own insight.
31. Therapist refuses seeing client in totalizing ways.
32. Therapist avoids seeing problems in totalizing ways.
33. Therapist refrains from seeing clients as having internal structures.
34. Therapist rejects trying to fix people into becoming normal.
35. Therapist avoids categorizing people.
36. Therapist avoids asking questions that verify client deficiency or inadequacy.
37. Therapist mostly avoids making statements and giving advice.
38. Therapist refrains from taking a hierarchical position.

**PART B: Influential Position**

1. Therapist provides opportunities for clients to more richly describe the alternative stories of their lives.
2. Therapist provides opportunities for clients to step into and to explore some of the neglected territories of their lives.
3. Therapist provides opportunities for clients to become more significantly acquainted with the knowledges and skills of their lives that are relevant to addressing the concerns, predicaments and problems that are at hand.
4. Therapist asks questions to open possibilities for clients to pursue what they value and hold precious.
5. Therapist provides for client an opportunity to refuse a normative criteria in the judgment of their activities and to focus on the consequences of one's activities in the shaping of one's life and relationship.
6. Therapist provides opportunities for clients to redefine their relationship with the problem and/or to re-experience their identity.
7. Therapist provides opportunities for clients to create a more preferred identity conclusion.
8. Therapist assists clients to move from what is known and familiar to what might be possible for him or her to know about his or her life and identity by asking questions.
9. Therapist asks questions that seem to lead to learning something new or neglected about clients' hopes, dreams, intentions, aspirations, and preferences.

10. Therapist provides opportunities for clients to reflect and evaluate their lives in a non-expert way.
11. Therapist provides opportunities for clients to deconstruct their dominant story.
12. Therapist objectifies client's problems.
13. Therapist avoids asking questions that seem to lead to known knowledge.
14. Therapist refrains from imposing his or her agenda and delivers interventions.

## Appendix B

### Transcript Notation

## Transcript Notation

(.)	A pause which is noticeable but too short to measure.
(.5)	A pause timed in tenths of a second.
=	There is no discernable pause between the end of a speaker's utterance and the start of the next utterance.
:	One or more colons indicate an extension of the preceding vowel sound.
<u>Under</u>	Underlining indicates words that were uttered with added emphasis.
CAPITAL	Words in capitals are uttered louder than the surrounding talk.
(.hhh)	Exhale of breath.
(hhh)	Inhale of breath.
( )	Material in parentheses are inaudible or there is doubt of accuracy.
[	Overlap of talk.
(( ))	Material in parentheses indicate clarificatory information, e.g., ((laughter)).
?	Indicates a rising inflection.
!	Indicates an animated tone.
.	Indicates a stopping fall in tone.
* *	Talk between * * is quieter than surrounding talk.
> <	Talk between > < is said quicker than surrounding talk.

(Gale, 1991, p. 105)

## Appendix C

### Transcript of White Session



- 1 MW: How are you Mathew?
- 2 M: I am fine, I just (became) like this =
- 3 [
- 4 MW: [((laughs))
- 5 M: = I can listen real hard!
- 6 MW: Can you? ((laughs))
- 7 M: (2.6) You Michael White? =
- 8 MW: = That's right, that's who I am yeah(.)
- 9 M: That's right. Hi Michael White ((shaking
- 10 hands)) =
- 11 MW: = Hi, it's good to meet you.
- 12 M: This is Andrew! ((pointing at his brother))
- 13 MW: Who is this?
- 14 M: Andrew
- 15 MW: Hello Andrew. ((shaking hands with
- 16 Andrew)) Please to meet you Andrew (.9)
- 17 So how old is [\*your\* = ((asking Mathew))
- 18 M: [he can listen hard! =
- 19 D: = Okay Mathew honey (wanna) sit down
- 20 on the chair now =
- 21 M: = Okay
- 22 MW: How old is your brother Andrew?

- 23 M: He is five.
- 24 MW: He is five, is he?
- 25 D: You are five =
- 26 MW: = you're five
- 27 M: okay
- 28 D: = Andrew is seven.
- 29 MW: Seven.
- 30 D: Shhhh relax sweetie shhhh \*okay\* ((talking  
31 to Andrew)) ((Andrew is coughing))
- 32 MW: And you are Diane?
- 33 D: I am Diane.
- 34 MW: Oh Diane ((shaking hands))
- 35 D: Nice to meet you.
- 36 MW: Yeah please to meet you =
- 37 M: = Look I got sna::ck! Okay.
- 38 MW: What do you got there? What's that?
- 39 M: A (inaudible) and Jorge!
- 40 MW: Sorry?
- 41 M: yeah (1.5) \*yeah\* ((nodding)) =
- 42 MW: = What's this >what's this< yellow thing?
- 43 Is this a =
- 44 [
- 45 D: [What's in there?

- 46 M: (inaudible)
- 47 D: Mathew, can you listen? =
- 48 M: Yeah!
- 49 D: = He asked you what's in the box? =
- 50 MW: = what's in the box? =
- 51 D: = no, no this box? ((showing at Mathew's  
52 yellow box))
- 53 M: ahhh a snack! =
- 54 MW: = a snack you can't (inaudible) =
- 55 D: = yeah ((laughs))
- 56 M: I have a grape juice, a purple grape juice =
- 57 D: = aha there is a purple grape juice in there =
- 58 MW: = yeah good =
- 59 D: = ((laughs)) =
- 60 MW: = It's always good to meet you and you are  
61 five years old? =
- 62 M: = yeah five years old Michael White.
- 63 MW: ((laughs))
- 64 D: ((laughs))
- 65 M: Just listen =
- 66 MW: = What do you think about all these  
67 cameras and things? (2.3)
- 68 M: just listen Michael White =

- 69 MW: = Have you > have you< seen this on  
 70 television? Do you want to have a look?  
 71 M: Yeah yeah  
 72 MW: Do you want to come with me and have a  
 73 look? =  
 74 M: = yeah =  
 75 MW: = and see your mom and brother on  
 76 television? =  
 77 M: = yeah! =  
 78 MW: = Come and have a look (1.0) See what it  
 79 looks like =  
 80 M: = see what it looks like ((went to see  
 81 camera)) =  
 82 MW: = yeah just have a look =  
 83 M: = yeah it's like a bee =  
 84 MW: = like a bee?  
 85 D: ((laughs))  
 86 M: could be look!  
 87 D: >\*this is gonna be the Mathew comedy  
 88 hour I think\*< ((laughs))  
 89 MW: See! You are on the television over there  
 90 >come on have a look< =  
 91 M: = wow =

- 92 MW: = Who is that? (2.2)
- 93 D: Do you want us to move? =
- 94 MW: = Who's that? Your mom and your brother,
- 95 ha? =
- 96 M: = uugrrrr ((Mathew's producing sounds)) =
- 97 MW: = okay ((laughs)) like a gorilla(.)come on
- 98 back ((laughs))
- 99 M: >wait wait< I (went) back (.9) don't move=
- 100 [
- 101 MW: [Who were you pretending to be
- 102 then like a gorilla? =
- 103 M: = yeah =
- 104 MW: = you were? =
- 105 M: = yeah! ((returning to his seat))
- 106 MW: ((heh)) Do you like gorillas? Yes? =
- 107 [
- 108 C: [We are just getting a back of you right
- 109 now, so: if [you ((cameraman talking to
- 110 White)) =
- 111 MW: [oh, is my back is my back
- 112 alright?
- 113 D: ((laughing))

- 114 M: my back! ((Mathew's showing at his back  
115 and everyone's laughing))
- 116 MW: yeah well =
- 117 D: = You have nice back I mean I don't have  
118 to worry about my hair then ((laughs))
- 119 M: okay ((Mathew plays in front of camera))
- 120 C: okay
- 121 MW: So you prefer to have something else not  
122 my back? = [
- 123 M: [(can listen close my ear just  
124 listen, listen Jorge, okay) =  
125 ((Mathew closing his ears with his  
126 hands))
- 127 MW: = So I can sit around here a little bit how  
128 would that be? (3.7) ((White moves to  
129 another chair)) (.hhh)
- 130 M: (we) listen to the movie =
- 131 D: = oh you like this movie? umm
- 132 MW: How am I now? ((asking camera team))
- 133 C: You're fine, you are fine.
- 134 D: (laughs) and you are happy (looking at  
135 Andrew)
- 136 MW: (1.8) So: uh um =

- 137 M: = Okay Jorge=  
138 MW: Andrew is seven years old?  
139 D: uh-huh =  
140 MW: = yeah okay (2.1) and you have the two  
141 children? =  
142 D: = uh-huh =  
143 MW: = \*yeah\* so =  
144 D: = yeah that's it =  
145 MW: = certainly Mathew is (live) one isn't he?  
146 D: That he is ((laughs))  
147 M: ((Mathew producing different sounds))  
148 MW: I couldn't work out if he was trying to be a  
149 gorilla or =  
150 D: = I think he is the beast =  
151 MW: = a beast =  
152 D: = a (inaudible) beast =  
153 MW: = the beast [\*okay\*=  
154 D: [((laughs))  
155 MW: = so I understand that your mom is here as  
156 well =  
157 D: = uh-huh =  
158 MW: = I just met her briefly (1.3) and a and a  
159 you are in the program [here?

160 D: [uh-huh] yeah

161 graduating in couple of months =

162 MW: = Are you really? =

163 D: = yeah =

164 MW: = yeah wow is that after how long? How

165 long is the program been? =

166 D: Two years =

167 MW: = Two years \*yeah\*=

168 D: yeah.

169 MW: And where do you go from there when you

170 graduate?

171 D: Well then I have to do my internship hours

172 I have to (1.1) accrue three thousand hours

173 [before I can =

174 MW: [thr::ee thousand!

175 D: = yes (laughs) =

176 MW: = before [before you?

177 D: [before I can take a licensing exam

178 MW: = really?

179 D: yeah ((nodding and smiling))

180 MW: (inaudible) How long will that take? =

181 D: = A thousand years [((laughs)) =

182 MW: [((laughs))



- 183           That's three hours a year ((laughs))
- 184   D:       [couple of years yeah ((laughs))
- 185   MW:   three thousand hours? =
- 186   D:       = ye:ah =
- 187   MW:   = and how do you arrange that? cause I am
- 188           not familiar with the system here?
- 189   D:       Um: (1.2) well you have to find
- 190           somewhere where you can a supervised
- 191           internship >right now< I am doing my
- 192           training-ship here at this at the center =
- 193   MW:   = yeah =
- 194   D:       = and I would like to stay on: as an intern
- 195           so that you just increase your number of
- 196           hours so you can (.7) you know =
- 197   MW:   = right so you can >stay< possibly stay here
- 198           as an intern and [see families here =
- 199   D:                   [hopefully yeah yeah
- 200   MW:   = three thousand [to stay =
- 201   D:                   [ye:ah doesn't that sound
- 202           incredible? I got two hundred now
- 203           ((laughs)) so it's digging my way to
- 204           [(inaudible) ((laughs))=
- 205   MW:   [(oh you only have two thousand to go)

- 206 D: = yeah =
- 207 MW: = and and (.) after that you (.) you can sit
- 208 for licensing and =
- 209 D: = take a written exam and oral exam =
- 210 MW: = yeah and then you are free to? (.)
- 211 D: = hang up you license [hang up your ( )]
- 212 MW: [yeah right okay]
- 213 and then go [to
- 214 D: [right and then right hopefully
- 215 and then find a new profession ((laughs))
- 216 MW: (laughs) oh well you are well on the way =
- 217 D: = yeah it's a (step) =
- 218 MW: = and your mom's been working in this
- 219 area for: quite some time?
- 220 D: Uh-huh yeah she's been a therapist for few
- 221 years now =
- 222 MW: = \*yeah yeah\* has that been your ambition
- 223 for some time? or is that a recent (.4) recent
- 224 shift for you? =
- 225 D: = umm (.6) well it's my interest in
- 226 psychology is kind of been there for a long
- 227 time [
- 228 MW: [yeah

229 D: in my previous life before my kids were  
230 born [((smiles))  
231 MW: [((laughs))  
232 D: I worked in area of public health =  
233 MW: = yeah =  
234 D: = and health education =  
235 MW: = yeah =  
236 D: = and I (.8) did that for about eight years  
237 and >I always thought< that I was really  
238 interested in psychology. So um then I was  
239 home with the boys =  
240 MW: = yeah =  
241 D: = for few years and then I just think my  
242 experiences with them made me really  
243 interested >we got involved in support  
244 groups< and um some peer counseling with  
245 families and parents who've been through  
246 the same kinds of things =  
247 MW: = yeah =  
248 D: = with children I had and (.4) I got really  
249 interested in that and got really fascinated  
250 with how people coped =  
251 MW: = yeah =

252 D: = with these things (.) so I decided to >you  
253 know< that I wanted to go >I knew I was  
254 going to go < to work some time this was a  
255 career that was very interesting to me and  
256 also it would allow me the flexibility I  
257 could have in taking care of their needs =

258 MW: = right \*yeah\* =

259 D: = so I signed up in here =

260 MW: pretty pretty good place to be coming from  
261 I think =

262 D: = uh-huh =

263 MW: = to get into this sort of work \*yeah\* (.) So:  
264 um and and you are already familiar with a  
265 reflecting the team process [and (inaudible)

266 D: [I've done it  
267 some =

268 MW: = You've done it some. So we don't need to  
269 talk a whole lot about what's  
270 [gonna happen today

271 D: [I think I know what's gonna happen =

272 MW: (yeah just briefly) we'll talk a bit and then  
273 we will switch places with some of the  
274 people from behind the screen we are gonna

275           be back with them and um (2.2) we will be  
276           the audience to their thoughts for bit and  
277           then (.) we will switch back again and I will  
278           just talk with you about your experience  
279           about their comments =  
280   D:       = okay =  
281   MW:     = yeah and what we traditionally do at the  
282           end is we would just get together and talk  
283           about the interview =  
284   D:       = ((nodding)) Okay sounds good =  
285   MW:     = and focus on the process rather than on  
286           you personally so: (1.2) group will be  
287           making comments and asking questions  
288           about the interview itself.  
289   D:       Okay.  
290   MW:     You might like to (.7) make some  
291           comments or ask some questions as well.  
292   D:       Sure.  
293   A:       (ahmmm)  
294   D:       Ohhh ( inaudible) ((talking to Andrew))  
295   M:       (inaudible)  
296   D:       (we can't be there) ((saying to Mathew))

297 MW: So what's: Mathew um when do you go to  
298 school here? Next year? Or this year?  
299 M: Yeah next year =  
300 MW: = next year is it? Okay =  
301 M: = This is (mommy's) school you just have  
302 it (inaudible) ((pointing at the camera and  
303 posing for camera))  
304 MW: ((laughs)) =  
305 D: = you like seeing yourself over there don't  
306 you? ((asking Mathew)) =  
307 MW: = Where can you see yourself? Oh in the  
308 mirror of course =  
309 M: (inaudible)  
310 MW: You can see what?  
311 D: ((laughs)) What can you see?  
312 M: (4.1) ((Mathew is quiet; putting his hand on  
313 eye))  
314 MW: [hehe  
315 D: [hehe =  
316 MW: = So do you and your mom get together in  
317 terms of this work a bit and talk about the  
318 work or? =  
319 D: = the work itself? =

- 320 MW: = yeah ((nodding)) =
- 321 D: = some some yeah \*yeah\*. We talk a lot
- 322 about (.) this family a lot ((laughs)) =
- 323 MW: = about this family your family =
- 324 D: yeah yeah we do we do talk about some
- 325 things related to work =
- 326 MW: = yeah =
- 327 D: = and it's been nice to have that as (.5) you
- 328 know someone close to me who can also
- 329 understand what I am (.) going through =
- 330 MW: = yeah yeah =
- 331 D: = professionally (.)
- 332 M: (Okay Jorge just listen) ((Mathew talking))
- 333 MW: yeah okay. And Andrew is seven seven
- 334 years old?
- 335 D: Seven and a half =
- 336 MW: = seven and a half and =
- 337 M: (inaudible)
- 338 MW: pardon? ((asking Mathew)) I am what?
- 339 M: You are Michael White!
- 340 MW: I am Michael White yeah =
- 341 D: = Mathew we know that =
- 342 M: = you are from other country =

- 343 MW: = I am from where?
- 344 M: You're from Australia.
- 345 MW: Yes Australia yeah =
- 346 D: ((laughs))
- 347 MW: = Do you know where Australia is?
- 348 M: What?
- 349 MW: Do you know where Australia is?
- 350 M: What?
- 351 MW: It's a long way away.
- 352 M: You are you are (inaudible) =
- 353 D: = He had to ride on the airplane for a long
- 354 long time =
- 355 MW: = yeah in fact I am still recovering from it =
- 356 D: = are you? =
- 357 MW: = I arrived yesterday, my world is still
- 358 going around in circles you know =
- 359 D: = you are in a completely different time =
- 360 MW: = if I ask the same question twice you know
- 361 that =
- 362 D: = ((laughs)) It's okay =
- 363 MW: = ((laughs)) =
- 364 D: = I'll answer the same question twice.



- 365 MW: so um (.) yeah and so (.) What happens with  
366 Andrew? I know that (.) is Mathew be  
367 going off to a place school or something?  
368 [What happens to him?  
369 D: [He is in the preschool =  
370 MW: [preschool =  
371 D: = he is in preschool for couple of years now  
372 MW: = yeah yeah =  
373 D: = and um he is in special ED preschool four  
374 mornings a week =  
375 MW: = yeah =  
376 D: = so he is pretty busy =  
377 MW: = yeah yeah and Andrew? =  
378 D: = and Andrew goes to school too he goes to  
379 public school =  
380 MW: = yeah =  
381 D: = he goes from 8:30 to 2:30 every day =  
382 MW: = yeah =  
383 D: = and they work on his sitting and on his  
384 standing =  
385 MW: = yeah =  
386 D: = that's what he is working on.  
387 MW: Really?

- 388 D: And hopefully some steps >he just had< hip  
389 surgery last summer so =
- 390 MW: = yeah =
- 391 D: = he had some seatback but (.) we've been  
392 working for few years on his getting head  
393 control =
- 394 MW: = yeah =
- 395 D: = and his ability to bear weight on his legs=
- 396 MW: = yeah =
- 397 D: = he works hard >but you know what< he  
398 likes to rest a lot ((laughs))
- 399 MW: \*yeah\* that makes sense when you are  
400 working hard [yeah you need to rest
- 401 D: [yeah he's been working five  
402 days a week too =
- 403 MW: = yeah =
- 404 A: ((Andrew is moving his head))
- 405 D: Uh! Andrew rel::ax ((talking to Andrew))
- 406 M: (you got get Jorge you get)
- 407 MW: I guess if he >is having< Andrew is having  
408 therapy five days a week that's pretty big  
409 program =

410 D: = it's very rigorous. Yes yes he has worked  
 411 really hard.  
 412 MW: So how is he doing with his sitting? is he?  
 413 D: You know he used to sit in a special chair=  
 414 MW: = yeah =  
 415 D: = where they straps his arms so he can work  
 416 on lifting his head =  
 417 MW: = yeah =  
 418 D: = and um (.4) it's getting stronger  
 419 MW: yeah?  
 420 D: It's getting stronger =  
 421 MW: = yeah =  
 422 D: = yeah (1.2) Mathew helps him lift his head  
 423 sometimes so ((smiles))  
 424 MW: Does he?  
 425 D: He pushes his head up ((smiles)) =  
 426 MW: = \*yeah\* that's good so so Mathew  
 427 supported for Andrew's times?  
 428 D: Yeah, well it makes him angry when  
 429 Mathew doesn't pick up his head he sort of  
 430 ( ) on him >mommy he is not picking his  
 431 head up< so that's how he gets his sibling  
 432 rivalry =

- 433 MW: = yeah =
- 434 D: = but Andrew's working hard =
- 435 MW: = yeah okay. >Alright< so (2.1)
- 436 D: don't touch that sweetie (talking to
- 437 Mathew)
- 438 MW: So what's like it for you to be out here in
- 439 front of the group behind the one-way
- 440 screen? =
- 441 D: = It's funny ((laughs)) [a bit odd
- 442 MW: [It's a funny experience yeah
- 443 D: I am glad I can't see them ((laughs)) =
- 444 MW: ((laughs)) yeah =
- 445 D: = It's kind of strange. It's good for me to
- 446 know because I've been on the other side
- 447 ((laughs))
- 448 MW: You would know most of the folks here or
- 449 quite a few folks here?
- 450 D: I didn't see a lot coming in but I think some
- 451 of them =
- 452 MW: = yeah =
- 453 D: = uh uh! ((Andrew's coughing)) Some of
- 454 them are very familiar cause I took the

455 course this summer with Jennifer and David  
456 so =  
457 MW: = yeah =  
458 D: = some of them are in the class.  
459 MW: I would be interested to know what would  
460 you be interested in talking about today,  
461 because I (.5) you know I don't have much  
462 information about =  
463 D: = uh-huh =  
464 MW: = this meeting and ah (.) which is usually  
465 my preference really =  
466 D: = yeah =  
467 MW: = you know just to (.) to start with people  
468 interested in starting at and =  
469 D: = well (.) this kind of all came about...  
470 honey let's put this away and can you sit  
471 still on the chair and let's turn this chair  
472 [around (talks to Mathew)  
473 MW: [can I also say you know I would be  
474 interested in what conditions would be the  
475 best for you? Whether you would like  
476 children to be present or you would prefer  
477 that [

- 478 D: [umm yeah I kind of prepared for that =
- 479 MW: = yeah =
- 480 D: = so my mom's gonna be grandma today =
- 481 MW: = Okay =
- 482 D: (Um did if I feel it's) when some things
- 483 when I talk about kids =
- 484 MW: = okay =
- 485 D: I probably would feel more comfortable
- 486 having =
- 487 MW: = okay =
- 488 D: = sweetie why don't you sit on chair okay?
- 489 ((talks to Mathew))
- 490 M: Okay.
- 491 D: Sit down all the way here you go can you
- 492 hold this on your lap? And sit real quiet?
- 493 M: \*yeah\*
- 494 D: Thank you.
- 495 M: I can do it!
- 496 D: Good boy.
- 497 MW: So you can make decision about that?
- 498 D: Yeah I feel comfortable doing it =
- 499 MW: = yeah =

500 D: = Well actually it all started with having to  
501 do with my professional paper which is a  
502 requirement for my graduation =

503 MW: = yeah =

504 D: = from the school. And I am working with  
505 Jenifer on that (.) and (.) as I said I've just  
506 always been (4.1) wondering how people >I  
507 mean know, I don't really know< but I  
508 wonder how people cope with not just kind  
509 of difficulties with kids but all kinds of  
510 tragic of life but particularly children with  
511 disabilities and (.) I am kind of a (.) trying  
512 to find out how people make meaning of  
513 their lives =

514 MW: = hmmm=

515 D: = when something catastrophic happens =

516 MW: = yeah =

517 D: = and in talking to Jenifer (.) especially it  
518 was like at the beginning of the school year  
519 in September I was really struggling with a  
520 lot of the same questions myself and it was  
521 becoming real difficult for me. Um um I've

- 522           been separated for a year from my  
523           husband=  
524   MW:   = so for one year? =  
525   D:     = for over a year we are going to be  
526           divorced =  
527   MW:   = right right =  
528   D:     = and just struggling with all the things  
529           about being a single parent and trying to  
530           remake my life with difficulties of having  
531           any children just particularly difficulties  
532           that I (.) have with my boys =  
533   MW:   = yeah =  
534   D:     = and I'm (.) just trying to (1.8) um figure  
535           out where to go from here.  
536   MW:   \*right\* =  
537   D:     = I am feeling a lot better now than I was at  
538           that time =  
539   MW:   = yeah =  
540   D:     = I mean school's been really absorbing so  
541           I get real absorbed in that =  
542   MW:   = and that's been helpful?  
543   D:     Ye:s.  
544   MW:   How's that being helpful?



545 [absorbing

546 D: [It's kind of being kind of a (container) for

547 me it's giving me a lot of structure to know

548 >you know even though< I would prefer to

549 do something else on the weekend than

550 write a paper (.) it's I know I have to do (.)

551 so I just do it and it's been really better for

552 me (.) in that way =

553 MW: = yeah =

554 D: = so I am really anxious about school being

555 over =

556 MW: = yeah =

557 D: = because I no longer (would) have that

558 kind of a structure and I have to figure out

559 where to go (.3) from there (.) with me with

560 the kids how we manage =

561 MW: = right right. I understand that you (would)

562 end up being primarily responsible for the

563 children, is that right?

564 D: They live with me. =

565 MW: = They live with you? =

566 D: = yeah they live with me. They visit their

567 dad every other weekend. =

568 MW: = right every other weekend =  
569 D: = uh-huh every other weekend and one  
570 night during the week they stay over night  
571 from after dinner till (.6) before breakfast  
572 they spend the night and he brings them  
573 back in the morning, and I have help at  
574 home =  
575 MW: = right right =  
576 D: = so that really helps me =  
577 MW: = right right (.) but the major responsibility  
578 for parenting would be on your shoulders =  
579 D: = right =  
580 MW: = is that correct? =  
581 D: = the decisions about and those decisions  
582 really (.) a lot of times are mine anyway =  
583 MW: = yeah =  
584 D: = just about schooling and doctors and  
585 surgeries and therapies =  
586 MW: = yeah =  
587 D: = and all those things =  
588 MW: = yeah =  
589 D: = that happen yeah =  
590 MW: = yeah =

591 D: = just primarily it's mine.

592 MW: Okay you mentioned a little bit about (.6)

593 how you had this a bit of a crisis around

594 meaning, was that? =

595 D: = uh-huh =

596 MW: = is that correct? Can you tell me a little

597 about what that crisis is about?

598 D: Umm I guess it's something that kind of

599 comes and goes and I think that a lot of it

600 had to do with Andrew's surgery he had

601 surgery this summer =

602 MW: = yeah =

603 D: = and it was really horrible he had (.5) both

604 of his hips were dislocated they had to be

605 bones had to be broken and reset and he

606 was in body cast for six weeks and (.6) um I

607 just felt totally overwhelmed (.2) he was in

608 a lot of pain and it went on when he was out

609 of cast the difficulties his discomfort went

610 on for probably about five months and I

611 mean it's been couple of months that he is

612 been comfortable again =

613 MW: = yeah =

614 D: = and I was feeling just really overwhelmed  
615 with (1.4) Andrew and how I was gonna  
616 continue to take care of him cause  
617 physically is getting hard =  
618 MW: = yeah =  
619 D: = and Mathew's got lots of >lots of lots of  
620 < energy =  
621 MW: = yeah yeah =  
622 D: = yeah and his own uniqueness ((laughs))  
623 (1.3) and um (1.5) I just felt like (.5) how  
624 was I gonna be able to get through the day  
625 no less the years and wondering too how  
626 and also struggling with how's gonna  
627 remake my own life >you know< I would  
628 love to have (1.2) a relationship again  
629 someday and I am overwhelmed with  
630 would anyone want to come in to the  
631 situation >you know< it's (2.2) ah so I was  
632 feeling kind of depressed around that =  
633 MW: = yeah yeah \*okay\* so \*wow\* so can I just  
634 check now with Andrew how's Andrew  
635 now? His pain is that =

636 D: = well he still has some discomfort like  
 637 when I dress him in the morning if I move  
 638 his hips (.8) together too fast >or even just  
 639 in the morning< cause he is pretty stiff =

640 MW: = right =

641 D: = he cries a little bit >but it doesn't go on  
 642 for a long time< and he'll have periods of  
 643 time when he cries when he is probably too  
 644 tired from the exercises >Mathew can you  
 645 sit down please < on the chair thank you  
 646 your microphone's gone ((laughs)) =

647 M: = my microphone =

648 D: = yeah just still for a little while sweetheart  
 649 you can look at your book, okay?

650 M: (inaudible)

651 D: Okay ((to Mathew)). Excuse me and um  
 652 >what was I saying?< he is (.) you know  
 653 Andrew there is always something going on  
 654 I mean he has seizure disorder and  
 655 sometimes lately his seizures are a little  
 656 more intense um (.8) he cries at night and  
 657 (.) sometimes I wonder weather it >I don't  
 658 know where it's from< it seems to me that

659           it is because he doesn't know it is the only  
 660           way of expressing himself =  
 661    MW:   = yeah =  
 662    D:     = he doesn't want to be in bed =  
 663    MW:   = yeah =  
 664    D:     = it's really hard for me (he just) >cry cry  
 665           cry< at night sometimes for an hour or so =  
 666    MW:   = yeah  
 667    D:     (1.5) the hardest thing is not knowing  
 668           what's troubling him and some thing is  
 669           bothering him because he can't tell me =  
 670    MW:   = yeah =  
 671    D:     = overall his health has been fairly good  
 672           (inaudible) um (.9) and a (.5) now that the  
 673           nightmare of the surgery is behind me I can  
 674           say I am glad we did it but it was just  
 675           horrible =  
 676    MW:   = \*yeah\* =  
 677    D:     = but he seems to be more comfortable now  
 678           \*so\* =  
 679    MW:   = and and (1.3) can he look forward to  
 680           being free free from surgery from this point  
 681           on? or is that? =

- 682 D: = not [necessarily  
 683 MW: [not necessarily?  
 684 D: = no cause there is likelihood that his hips  
 685 could become dislocated again =  
 686 MW: = right =  
 687 D: = I mean we really we really put a lot of  
 688 effort, time, and money into idea of getting  
 689 him having excellent follow up physical  
 690 therapy we found excellent therapist =  
 691 MW: = yeah =  
 692 D: = who is working with him five days a  
 693 week =  
 694 MW: = yeah =  
 695 D: = in hopes that he will gain the muscle  
 696 strength to start to do some standing  
 697 because really that would be his best  
 698 chances of [  
 699 MW: [of getting his  
 700 D: = of keeping his hips in place but (.9) there  
 701 is always that possibility he is only seven =  
 702 MW: = yeah =  
 703 D: = and lots of kids have it done again \*you  
 704 know later in their life\*

705 MW: When you said we who (.9) did you work  
706 with a team?  
707 D: I guess I am still talking about my husband  
708 (laughs) I mean you know because he is  
709 involved in making decisions in helping to  
710 pay for this things so is important =  
711 MW: = yeah =  
712 D: = and we feel the same way about Andrew  
713 and his care (.) we try to have a cooperative  
714 spirit about =  
715 MW: = right =  
716 D: = about the kids and what they need  
717 MW: okay so =  
718 D: = so: =  
719 MW: = and that teamwork survived survived the  
720 separation? The teamwork  
721 [in relation to children? =  
722 D: [uh pretty good pretty good yeah I mean I  
723 do most of the like 95 percent of the  
724 research and I tell him what I found out and  
725 but (.6) he certainly (.7) was very involved  
726 with Andrew in the hospital when he was  
727 there for the surgery =



- 728 MW: = yeah=  
729 D: = we really that's been our primarily goal is  
730 to keep that spirit in (tack)  
731 MW: = \*keep that going\* =  
732 D: = absolutely essential =  
733 MW: = yeah =  
734 D: = we both know that we need each other for  
735 that (.4) so we really try to work hard >and  
736 I guess I do feel like I have < a team  
737 anyway I mean between (.) the therapists  
738 and Andrew's teachers and my parents and  
739 (.5) um his doctors >I mean< it really is (.9)  
740 it's a community ((smiles))  
741 MW: yeah yeah and that's been important?  
742 D: It's been essential [yeah  
743 MW: [yeah yeah is that you  
744 mentioned this crises that you went through  
745 that was around Christmas was it? Or?  
746 D: Well it was before that actually it was  
747 probably summer through maybe (.9)  
748 October or something =

749 MW: = yeah right (.) and you mentioned  
750 something about getting absorbed in work  
751 in a sense =  
752 D: = getting what?=  
753 MW: = getting absorbed in the work =  
754 D: = in schoolwork? =  
755 MW: = yeah did that help in some way?  
756 [Or not?  
757 D: [It did yeah at the beginning it was hard I  
758 was having a hard time getting back into it=  
759 MW: = yeah =  
760 D: = because of just (I was feeling) so poorly=  
761 MW: = yeah=  
762 D: = and uhh (1.5) it does it gives me you  
763 know it gives me that sense of purpose =  
764 MW: = yeah right =  
765 D: = that I that's really important =  
766 MW: = important?=  
767 D: [yeah  
768 MW: [yeah. So:: (2.0) I made couple of notes  
769 here and if that's okay and come back to  
770 them  
771 D: = sure =

772 MW: =um (4.0)  
 773 D: (inaudible) ((Diana talking to Mathew))  
 774 what's in it? (asking Mathew)  
 775 MW: Wow! There are some treats yeah  
 776 D: ((laughs))  
 777 M: They are not treats they are snacks.  
 778 D: They are snacks ((laughs))  
 779 MW: Snacks okay I am sorry treats mean  
 780 [something else  
 781 D: [treats are sweet ((laughs))  
 782 MW: ((laughs))  
 783 D: >Snacks are crackers< =  
 784 MW: = ri:ght okay so the snacks =  
 785 D: = yeah.  
 786 MW: So: (1.4) um (1.3) the getting absorbed in a  
 787 work gave that sense of purpose that was  
 788 really important to you, what (.) how would  
 789 you name the purpose? I mean what what =  
 790 D: = umm (2.2) how I name it? (4.2)  
 791 MW: ((White puts his notes on the ground))  
 792 D: Well oh your water just spilled. ((laughs))  
 793 M: oh wow (.) must be jet leg ((smiles)) =  
 794 D: = must be [true

795 MW: [I am blaming it on jet leg =

796 D: ((laughs))

797 MW: = few days after you been (.) traveling here

798 ((stands up and takes off his jacket)) =

799 D: = you know what's most (inaudible) me is

800 the sense of self-esteem and keeping it in

801 tack and feeling like I really accomplish

802 something. It's really important >it's

803 always been< important to me =

804 MW: = yeah \*yeah\* =

805 D: = and with kids >you know< when

806 sometimes at the end of the day is like what

807 did I accomplish? >you know< =

808 MW: = yeah =

809 D: = and I (.5) um (1.4) and particularly since

810 it's been so stressful the last year since my

811 husband >actually it was stressful before<

812 he moved out too =

813 MW: = \*yeah\* =

814 D: but (.) (I'll tell you) I can have a bad day

815 but when I get a paper back in the mail with

816 an A on it then I would feel like everything

817 was fine! [((laughs)) =

- 818 MW: [((laughs))
- 819 D: = so I guess it is really important to have
- 820 that external kind of validation =
- 821 MW: = yeah =
- 822 D: = that I have (.4) you know =
- 823 MW: = \*right\*
- 824 D: = that I can sit down at my computer and
- 825 (.5) turn out paper that's =
- 826 MW: = right =
- 827 D: = creative \*I mean\* it's the creativity I
- 828 think that's really important =
- 829 MW: = right so you can reflect a bit on
- 830 [that
- 831 D: [oh yeah
- 832 MW: = and gain that sense of self-esteem =
- 833 D: = ye:s yes =
- 834 MW: = \*yeah\* so what sorts of things would you
- 835 be (valuating in) yourself (.5) for when you
- 836 are able to reflect on this? =
- 837 D: umm I think (.7) um (1.3) one thing is the
- 838 discipline that I had to [sit down and do this
- 839 MW: [right yeah \*yeah\*
- 840 D: = to (take) out the time for myself to do

841           that =

842   MW:   = right =

843   D:     = and umm=

844   MW:   = so it's discipline \*yeah\* =

845   D:     = A-ha (.) and um creativity

846   MW:   (.2) yeah =

847   D:     = and my intellectual capabilities that they

848           are still intact despite of having giving birth

849           to two children ((laughs)) which I

850           sometimes doubt it that it was there

851           ((smiles))

852   MW:   So put you back in touch with that?

853   D:     Yeah ((smiles)) =

854   MW:   = yeah \*okay\* (nodding) =

855   M:     [Mommy! (inaudible) My snack!]

856   MW:   so it's very rewarding for you personally =

857   D:     = very rewarding and and excuse me

858           (talking to Mathew) You want to unpack?

859   M:     \*yeah\*

860   D:     Okay. All you have to do is take this out

861           and open them up >put your hand in there<

862           see there is crackers and cheese and apple

863           and purple grape juice.

864 M: Okay! =

865 D: Okay, you are all set. Um (1.9) what

866 question I am sorry?

867 MW: um I was thinking about the crackers and

868 the cheese and the grape juice =

869 D: = oh would you like some? =

870 MW: = no it's ok = ((smiles))

871 D: ((laughs))

872 M: Eat the crackers!

873 MW: I would want a cracker >can I have a

874 cracker<?

875 M: (inaudible)

876 D: Give a cracker to Michael.

877 M: Ok. (2.0) watch this

878 MW: Thanks!

879 M: here you go. (giving cracker to Michael

880 White)

881 MW: Are these good crackers?

882 M: yeah they are crackers >thank you<

883 MW: [mmm

884 M: [you're welcome!=

885 MW: = mmm it tastes like treats to me =

- 886 D: = ((smiles)) ye::ah (.8) depends on your  
 887 [perspective ((laughs))  
 888 MW: [((laughs))  
 889 M: I can't move this box =  
 890 D: = You can't move it? (helps Mathew move  
 891 the box in his chair) Here you go.  
 892 MW: So just generally um =  
 893 M: = can't move, I can't! =  
 894 D: ((helps Mathew move the box to his lap))  
 895 (.3) I think school gave me a sense of (2.2)  
 896 esteem that I was starting >that was being <  
 897 eroded in my marriage ((nodding)) =  
 898 MW: = ((nodding)) hmm okay =  
 899 D: = just \*you know\* feeling pretty terrible  
 900 about the whole situation about myself and  
 901 not getting any strokes any longer and (.4)  
 902 it was kind of really nice external source =  
 903 MW: = right =  
 904 D: = kind of validated my (1.2) what I felt was  
 905 there and just had to tap into it again =  
 906 MW: = right, so it's a matter of >sort of<  
 907 reclaiming some things that you wouldn't =  
 908 D: = uh-huh =



- 909 MW: = lost not lost but would be buried =
- 910 D: = uh-huh =
- 911 MW: = around your experiences.
- 912 D: And I think too a sense of a goal and
- 913 working toward accomplishing it =
- 914 MW: = \*right\*=
- 915 D: = um with Andrew I had so many um (1.1)
- 916 so many years of (.9) hope you know and I
- 917 would put my heart and soul into trying to
- 918 do some thing about it =
- 919 MW: = hmm =
- 920 D: = find a new therapy or >you know<
- 921 whatever it was and then haven't ultimately
- 922 make that much of a difference =
- 923 MW: = hum =
- 924 D: = it was very disheartening and very
- 925 frustrating =
- 926 MW: = \*uh-huh\* =
- 927 D: = so it was an opportunity to do something
- 928 that [had =
- 929 MW: [yeah
- 930 D: = a goal that I could accomplish =
- 931 MW: [yeah

- 932 D: = \*so\*.
- 933 MW: So: that process >you know< (1.0) of
- 934 actually what believing something could be
- 935 done that was (.5) going to make a world of
- 936 difference (.6) and then pursuing that with
- 937 therapist but finding out that it didn't work
- 938 quite how you wanted it and hoped it would
- 939 be it's pretty demoralizing experience =
- 940 D: = yeah. =
- 941 MW: [yeah
- 942 D: = you know (4.3) it's terrible but you see I
- 943 always (1.3) I always have that hope even if
- 944 I just fall down and I just picked myself
- 945 up=
- 946 MW: = yeah =
- 947 D: = and I picked myself and I sometimes I
- 948 withdraw for awhile from Andrew and
- 949 everything with him I just have to take
- 950 some time out =
- 951 MW: = \*uh-huh\* ((nodding)) =
- 952 D: = and I then (.) I kind of get rejuvenated
- 953 again but it's always dangerous I know to
- 954 have that hope because you fall harder.

- 955 MW: Yeah yeah =
- 956 D: = I do that a lot =
- 957 MW: = I guess hope is important but I guess um
- 958 (1.3) um (.2) the issue is about the extent to
- 959 which it um dominates in terms of what you
- 960 are doing and how you are generally
- 961 approaching things. Is something been a
- 962 shift with that? Like you got a different sort
- 963 of relationship with hope? (1.3) You know
- 964 you mention that (.9) you did have this low
- 965 time but (.3) you actually came out of that
- 966 (.4) being absorbed in your work helped a
- 967 lot. >I was wondering if there were< some
- 968 other things as well that changed for you?
- 969 D: (3.7) um (1.9) How I came out of that
- 970 period of time?
- 971 MW: Yeah ((nodding))
- 972 D: Well medications helped too.
- 973 MW: Did it? =
- 974 D: = yeah anti-depression medication =
- 975 MW: = yeah? =
- 976 D: = yeah that helped a lot (1.1) and =
- 977 MW: I was [thinking =

978 D: [I think  
 979 MW: = sorry =  
 980 D: = no go head =  
 981 MW: = [well I was thinking  
 982 D: [>that's not the answer you were looking  
 983 for< I am sure drugs (laughs)  
 984 MW: [no no I am not looking for any  
 985 particular answer I am interested in what  
 986 you are interested in talking about and =  
 987 D: = right what else changed in that time =  
 988 MW: = I am just wondering whether your  
 989 relationship to hope changed as well?  
 990 D: um: (1.5) my relationship to hope?  
 991 MW: Yeah.  
 992 D: (5.5) I don't know. I mean it's like I hang  
 993 on to hope because it's what gives me (1.4)  
 994 the motivation to get up and go on every  
 995 day.  
 996 MW: Sure >yeah< sure I wasn't thinking that it  
 997 wasn't helpful force in your life  
 998 D: (.3) How do you mean? I'm trying to  
 999 imagine how my relationship with it  
 1000 changed. (4.0) I think my hope (1.0) my

1001 relationship with hope in relation to  
 1002 Andrew has changed =  
 1003 MW: = \*yeah\* yeah can you tell me about that?  
 1004 D: um (1.4) for the most part I mean my hopes  
 1005 for him since he was born changed  
 1006 dramatically =  
 1007 MW: = yeah =  
 1008 D: = when I was when I um (1.5) when he was  
 1009 born I hoped that he would overcome  
 1010 everything that he had =  
 1011 MW: = yeah =  
 1012 D: = he was devastatingly ill as a new born =  
 1013 MW: = yeah =  
 1014 D: as a premature baby (.6) and nobody  
 1015 thought that he would live to the next day  
 1016 and I so I had hope that this little boy was  
 1017 so strong that he can keep overcoming all  
 1018 these (.7) horrible obstacles =  
 1019 MW: = yeah.  
 1020 D: and physically he did! I mean he survived  
 1021 \*that was really miraculous\* um (.7) and I  
 1022 had different hopes all the time then I  
 1023 hoped >you know< that he will be able to

1024 say "mommy" some day then I hoped that  
1025 he will be able to sit up my hopes were kept  
1026 being lowered =  
1027 MW: = right =  
1028 D: = um (.8) and I got kind of (.5) my  
1029 relationship with hope became quite  
1030 rejuvenated about three years ago when I  
1031 heard about the program (.9) not far from  
1032 here in a small town about hundred miles  
1033 from here that was teaching kids like  
1034 Andrew how to sit stand and walk =  
1035 MW: = yeah =  
1036 D: = and I was really afraid of hope I was (.7)  
1037 real cautious about it  
1038 MW: [yeah  
1039 D: = because it was so painful  
1040 MW: [yeah  
1041 D: = but I threw myself into it and we move up  
1042 there for a time and got Andrew in a  
1043 program (.) and (.) got the program going  
1044 down here >so in that sense< it helped a lot  
1045 of other people but Andrew didn't make  
1046 much progress in it =

- 1047 MW: = \*right\* =
- 1048 D: = so once again my (.5) hopes became more  
1049 that he would be pain free =
- 1050 MW: = yeah =
- 1051 D: = and that's why we did the surgery >I  
1052 mean put him in pain< but hope to with the  
1053 ultimate goal of having um (2.2) I think my  
1054 hope for Andrew is that he's a (1.3) that he  
1055 is content and at peace.
- 1056 MW: yeah \*yeah\*
- 1057 D: (1.3) and that's a hope I have to hang onto=
- 1058 MW: = yeah =
- 1059 D: = because that's that's (.4) the meaning in  
1060 his life.
- 1061 MW: ye:ah I think hope is really important I  
1062 wasn't (.) wanting to cast it out or nothing =
- 1063 D: [no I know =
- 1064 MW: = but I was thinking about your relationship  
1065 with hope yeah]
- 1066 D: = yeah thinking about how it has changed  
1067 yeah]
- 1068 MW: = and just wondering whether or not  
1069 coming out of this um (1.6) down time that

- 1070           you had whether you come out with a
- 1071           different sort of a relationship to hope um =
- 1072   D:       = yeah =
- 1073   MW:     = and what you sort of \*relationship\*?
- 1074   D:       Well I feel (.8) hopeful once again =
- 1075   MW:     = yeah =
- 1076   D:       = very hopeful for myself =
- 1077   MW:     = \*yeah\*=
- 1078   D:       = um (1.0) for um (2.4) for Mathew and I
- 1079           [you know
- 1080   MW:     [yeah
- 1081   D:       (2.5) I think it's always in question about
- 1082           Andrew =
- 1083   MW:     = yeah =
- 1084   D:       = but (2.3) I have a lot hope about this little
- 1085           guy he makes my heart sing ((smiles))=
- 1086   MW:     = ((laughs))=
- 1087   D:       = and keeps me up at night =
- 1088   MW:     = Does he? =
- 1089   D:       = He likes to sleep with his mom so (.7) um
- 1090   M:       ((spreading his arms in approval))
- 1091   A:       ((coughing))



- 1092 D: yeah relax sweetie ((saying to Andrew))
- 1093 and you know I am starting to get hope
- 1094 about my own life =
- 1095 MW: yeah yeah [okay. \*so\*
- 1096 D: [my social life's gotten somewhat
- 1097 better =
- 1098 MW: = \*yeah\* =
- 1099 D: = but you know =
- 1100 MW: = that's sort of thing I was [thinking of
- 1101 D: [yeah it's just
- 1102 (1.4) yeah >I mean I really< I am more in
- 1103 touch with =
- 1104 MW: = yeah =
- 1105 D: = hope again =
- 1106 MW: = so you've been allocating some of the
- 1107 two (self) in a way =
- 1108 D: = yeah =
- 1109 MW: = more so right? =
- 1110 D: = yes I am trying to do [that
- 1111 MW: [yeah (.)
- 1112 \*okay all right.\* How did you achieve that?
- 1113 D: (1.0) Which part? =
- 1114 MW: = [to allocate some of that hope to yourself?

- 1115 D: [to allocate some of it to myself? =
- 1116 MW: = yeah
- 1117 D: Oh I think it was a question of survival =
- 1118 MW: = Was it? =
- 1119 D: = \*yeah\* that I knew that there were certain
- 1120 things that I had to do for myself or I
- 1121 wasn't gonna survive for these boys =
- 1122 MW: = wow =
- 1123 D: = um one of the things that has been helpful
- 1124 to me is (3.4) it's hard I act as it is already
- 1125 done but accepting my limits ((laughs)) =
- 1126 MW: = yeah yeah =
- 1127 D: = I always wanted to be able to do so much
- 1128 and knowing that when I (set out) to do so
- 1129 much is when I >I think that's <when I fell
- 1130 so hard (.2) you know because (.5) when I
- 1131 go through crises is because (1.1) it's hard
- 1132 for me to accept that that I may not always
- 1133 be >that I will not< be able to care for
- 1134 Andrew in my home my whole life =
- 1135 MW: = right [okay
- 1136 D: [that I am not going to be able to lift
- 1137 [him soon =

- 1138 MW: [yeah yeah
- 1139 D: = not only just physically but emotionally =
- 1140 MW: = hmm =
- 1141 D: = that I cannot do this by myself =
- 1142 MW: = hmm =
- 1143 D: = that I'm keep getting more help and also
- 1144 to allow myself to have some time away =
- 1145 MW: = right. So this hope (.4) was extending
- 1146 your posture limits in some way but =
- 1147 D: = yes =
- 1148 MW: = now [you are able to =
- 1149 D: [yes absolutely, that's absolutely
- 1150 right. It was extending me beyond my
- 1151 limits =
- 1152 MW: = yeah right.
- 1153 A: ((Andrew's coughing))
- 1154 D: Oh my goodness that's a nasty cough
- 1155 \*that's a nasty cough yeah you're ok\*
- 1156 (talking to Andrew) umm (1.1) yeah it was.
- 1157 It was like um (3.1) it was like >you know<
- 1158 the hope had supernatural powers =
- 1159 MW: = yeah yeah yeah =

- 1160 D: = and um (1.3) it was taking me beyond  
1161 place where I can really be =
- 1162 MW: = right
- 1163 D: (1.2) >that's hard to accept< cause I want to  
1164 be able to do everything =
- 1165 MW: = ((laughs)) =
- 1166 D: = excellent. ((laughs))
- 1167 MW: But that's something that's happened over  
1168 the last um months in a sense =
- 1169 D: = it's a process =
- 1170 MW: = yeah =
- 1171 D: = I have to say
- 1172 MW: [yeah right
- 1173 D: = it's ongoing process =
- 1174 MW: [yeah
- 1175 D: = but definitely more recently
- 1176 MW: [would you say more recently?  
1177 Would you say it's a positive development?  
1178 That hope doesn't extend your (inaudible)  
1179 your limits so much? =
- 1180 D: [I think so because I think it's real
- 1181 MW: = yeah =
- 1182 D: = it's real for me, it's real life =

1183 MW: = okay so there are two major changes in  
1184 your relationship with hope. um (.6) One of  
1185 it, is that it doesn't extend your (inaudible)  
1186 so much (1.0) and the other one is that  
1187 you're allocating some of it to yourself, is  
1188 that right?

1189 D: Yeah.

1190 MW: Okay. ((writing notes))

1191 M: ((choking on food sounds))

1192 MW: (3.3) um (2.0) How are those snacks going?

1193 M: going yeah going good =

1194 MW: [pretty good?

1195 D: [wanna try some apple? ((asking  
1196 Mathew))

1197 M: (.2) Want some apple? You have some  
1198 apple! Okay? ((pointing at White))

1199 MW: ((laughs))

1200 D: ((laughs)) he will feed you whether you  
1201 want it or not. ((laughs))

1202 M: Here you go! ((giving apple to White))

1203 MW: Thank you very much ((coming closer to  
1204 get the apple)) thank you that's =

1205 M: = thank you =

1206 MW: = okay, can I eat it in a minute? Do I have  
 1207 to eat it straight away [or can I =  
 1208 M: [yeah yeah  
 1209 D: He can wait?  
 1210 MW: [I can wait?=  
 1211 M: No EAT it! =  
 1212 MW: = I have to eat it now?  
 1213 D: [he can't talk and eat]  
 1214 MW: It's hard to talk while I am eating. I'll just  
 1215 put it here for a minute I'll eat it before you  
 1216 finish off today ok?  
 1217 M: (eat::: it:::):  
 1218 D: Mathew  
 1219 MW: Do you like apple?  
 1220 M: (.) eat it it's good!  
 1221 D: Mathew =  
 1222 MW: = Is an apple a treat or snack?  
 1223 M: (it's nice) it's a snack  
 1224 D: ((laughs))  
 1225 MW: ((laughs)) It's a snack, okay.  
 1226 M: It's a snack!

1227 D: Mathew honey you want us (inaudible) just  
 1228 a little bit later okay he is talking to  
 1229 mommy, okay? =  
 1230 M: = okay =  
 1231 D: = All right, thank you.  
 1232 MW: ((laughs)) okay yeah (.) so um are we  
 1233 talking what's interesting to you to talk  
 1234 about or? =  
 1235 D: = uh-huh yeah it is =  
 1236 MW: um what's interesting about talking about  
 1237 this because we start a bit of the  
 1238 conversation [and I don't know  
 1239 D: [yeah well it's (1.3) interesting  
 1240 in talking >I mean< (.9) talking about hope  
 1241 cause it's kind of like a theme =  
 1242 MW: = yeah =  
 1243 D: = of my life =  
 1244 MW: = yeah =  
 1245 D: = and recognizing when hope is good and  
 1246 when when it can take me beyond the place  
 1247 MW: = yeah =  
 1248 D: = and that it's not just about >that it can  
 1249 be< for myself too.

1250 MW: Yeah.

1251 D: That's really (1.6) I didn't think of it in

1252 terms of my hoping for myself.

1253 MW: Right, was it important to think about like

1254 that? Is that a helpful way of thinking about

1255 it or? =

1256 D: = um (3.0) yeah yeah. >I mean cause I

1257 invested so much< time in (.4) hoping that

1258 the children will be okay hoping that my

1259 marriage would work out hoping that you

1260 know everything =

1261 MW: = yeah =

1262 D: = and having to let go of those hopes is

1263 really (.6) important so (.4) I guess it is kind

1264 of shifting my relationship to hope =

1265 MW: = yeah yeah yeah =

1266 D: = \*and you know\*(1.7) having the same

1267 amount of hope but just re-allocating it =

1268 MW: = I think it's a really big achievement for

1269 people to shift their relationship to hope (.)

1270 particularly um they've been in a sort of

1271 situation that you've been and in relation

1272 with children and marriage and (.2) I guess



1273           (.) I understand from talking to women that  
 1274           it's a particularly big achievement for  
 1275           women because um they get so recruited in  
 1276           hoping for everybody else and =

1277   D:       = ye::ah =

1278   MW:     = and (.2) not that it's a negative (trait) I  
 1279           guess it is a really positive one but =

1280   D:       = I am glad I have it, [I don't think it's  
 1281           negative]

1282   MW:     [yeah yeah] but I guess um (.5) the fact that  
 1283           you are (not) excluded from this now is  
 1284           really interesting development =

1285   D:       ((nodding))

1286   MW:     = ye::ah. So: um (.) and (.) we started off  
 1287           (.) you talked a little bit about how you got  
 1288           interested in how people cope with things =

1289   D:       = uh-huh=

1290   MW:     = and umm I am getting to find out a little  
 1291           bit about >you know< how you coped I  
 1292           mean what's working for you? =

1293   D:       = \*yeah\* =

1294   MW:     = and um (1.0) so: I guess that's probably  
 1295           why I've been asking the questions that I've

1296            been asking. You mentioned some other

1297 things about (.2) can I say is the teamwork

1298                    changed a bit also in the last? =

1299 D: = the whole team or the team between their

1300 dad and I?

1301 (cut at 46:30)

1302 MW: You mentioned that (.7) um medication

1303 helped a bit to get you out of spot=

1304 D: [uh-huh

1305 MW: =that you were in (.4) but you haven't

1306 experienced going back there again =

1307 D: = yeah =

1308 MW: = and we talked about how you changed

1309 your relationship to hope and =

1310 D: ((noddin))

1311 M: [Michael?]

1312 MW: Yeah?

1313 M: You want these? =

1314 MW: = No [I'll have one later on okay?

1315 D: [I think that's enough sweetheart, it's

1316            too much you won't be able to eat lunch =

1317 ((talking to Mathew))

1318 MW: = He is very generous =

- 1319 D: = very generous =
- 1320 MW: = yeah \*yeah\* very generous =
- 1321 D: if it's ice-cream (inaudible) ((laughs))
- 1322 MW: ((laughs))
- 1323 D: \*ok shhhh\* you be a very good boy now
- 1324 ((saying to Mathew))
- 1325 MW: yeah and (1.3) and um (2.0) um (.) just
- 1326 wondering if there's some change in terms
- 1327 of a teamwork itself? if it can also account
- 1328 you know for (.5) the steps that you are
- 1329 taking to get back (.3) back your life in
- 1330 some way so =
- 1331 D: = yeah umm (1.6)
- 1332 MW: Is there more teamwork than it was? Or is
- 1333 the teamwork the same? Or is it changed? =
- 1334 D: = I don't know if it is changed um =
- 1335 MW: = I don't mean just with Steve I mean
- 1336 generally you know with all the folks =
- 1337 D: = um yeah I am trying to think how that
- 1338 works? (3.7) I feel like I'm kind of more
- 1339 you know back into the team =
- 1340 MW: = back in to the team? =
- 1341 D: = ye::ah back on the team =

- 1342 MW: [yeah
- 1343 D: = um (3.1) you know (.3) I've been kind of
- 1344 captain of this teams =
- 1345 MW: = yeah =
- 1346 D: = for a long time =
- 1347 MW: = yeah =
- 1348 D: = and I am still captain of the team um (1.9)
- 1349 I keep trying every once in awhile to share
- 1350 that (1.2) position with their dad but um
- 1351 (1.0) he isn't really take the ball but >you
- 1352 know what I am trying to do is< to maybe
- 1353 allocate with more of some of the things
- 1354 that I can't do =
- 1355 MW: =hmm =
- 1356 D: = and or even for their care or taking to
- 1357 appointments or whatever (.4) being less
- 1358 (.7) hopefully trying to let go of some of
- 1359 that so that I can (.5) have some of that
- 1360 more for myself =
- 1361 MW: = hmm hmm =
- 1362 D: = by maybe being better leader by
- 1363 delegating other people a little better.
- 1364 ((smiles))

- 1365 MW: I guess it's a bit hard if other people don't  
1366 take the ball you know? =
- 1367 D: = yeah=
- 1368 MW: = That makes it pretty difficult, doesn't it to  
1369 get out of that captain position?
- 1370 D: [yeah but you know actually he would take  
1371 the ball but (.) it's like I am still the chief  
1372 executive =
- 1373 MW: [right okay ((nodding))
- 1374 D: [I still make the final decisions (.3) but he  
1375 does financially support it so that's his job  
1376 which he does well.
- 1377 MW: [\*okay right okay good\* um (2.0) in terms  
1378 of the self-esteem that you mentioned that  
1379 you're being reclaiming and sense of  
1380 accomplishment getting more in touch with  
1381 your own (self) would you say self-  
1382 discipline is that what you meant when you  
1383 said discipline or?
- 1384 D: umm (2.6)
- 1385 MW: you said discipline and creativity =
- 1386 D: = yeah I meant self yeah I know I also have  
1387 lots of discipline self-discipline I think um

- 1388 A: ((Andrew coughing))
- 1389 D: ugh okay um (1.7) did that hurt a little bit?
- 1390 (asking Andrew) hm yeah um (5.7)
- 1391 I think it was a discipline it's kind of a
- 1392 challenge to myself to um (1.8) to in a
- 1393 midst to what seemed to me and others as
- 1394 chaos to be able to (carve) out the time for
- 1395 myself >but I have to say something about<
- 1396 the discipline I think it's kind of two edge
- 1397 cause for me I've always been pretty
- 1398 disciplined so some of what I am trying to
- 1399 experiment with is (.) not being so
- 1400 disciplined.
- 1401 MW: Right okay that's what I've guessed
- 1402 [actually (inaudible)]
- 1403 D: [yeah I mean I just kind of letting go of it a
- 1404 little bit =
- 1405 MW: [yeah yeah
- 1406 D: = is much more freeing than ((nodding)) =
- 1407 MW: = right so you (won't) be so disciplined? =
- 1408 D: = right! yeah that is that's true =
- 1409 MW: = like a refusal in a sense =

- 1410 D: = ye:ah just kind of being (1.0) letting  
1411 things just happen a lit more and not  
1412 worrying so much about the consequences.
- 1413 MW: ((writing notes while she was talking))  
1414 Okay, how are you achieving that in a  
1415 situation that's? =
- 1416 D: = well I think I can talk about it in a relation  
1417 to school I mean I always I allow myself to  
1418 say well I can take extension on a paper I  
1419 never done that before ((smiles))
- 1420 MW: ((laughs))
- 1421 D: (.9) I haven't had to yet but I just allow  
1422 myself to think that I can do that =
- 1423 MW: =that that's okay
- 1424 D: [that's okay =
- 1425 MW: = yeah
- 1426 D: = and that a lot of things are okay that  
1427 doesn't something doesn't have to be  
1428 perfect it's just (.6) getting through it in  
1429 (tack) that's important =
- 1430 MW: = \*yeah okay\*. So how does that fit with  
1431 um (.8) this changing relationship with  
1432 hope? Are they connected this refusal to be

1433           so [disciplined and changing your  
1434           relationship to hope?  
1435   D:       [ohhh you know it's something that is  
1436           happening now =  
1437   MW:           [yeah  
1438   D:       = it's hard to say what  
1439   MW:           [yeah  
1440   D:       = I'm kind of wondering how it's gonna  
1441           (3.8) >you know what it is though< it's  
1442           kind of like hope that (1.2) well in allowing  
1443           myself to to um have a different  
1444           relationship with a discipline =  
1445   MW:   = yeah =  
1446   D:       = um it maybe (1.3) um (2.0) there is hope  
1447           in that (.2) my life can be different that it  
1448           has been =  
1449   MW:   = right (1.9) okay so (that's) the connection  
1450           between the two in that sense =  
1451   D:       = yeah =  
1452   MW:   = yeah =  
1453   D:       = it's kind of opening another possibility  
1454           and way to be =



1455 MW: = okay (.7) your mom is sitting behind one-  
1456 way screen here and um (1.0) I guess she  
1457 knows already that you've been reclaiming  
1458 self-esteem and sense of accomplishment  
1459 and getting more in touch with intellectual  
1460 capabilities and so on, right?  
1461 D: She intuitively knows a lot of things about  
1462 me that I don't have to say to her =  
1463 MW: = How would she know these things  
1464 intuitively? Are you close? =  
1465 D: = Yes. =  
1466 MW: = You are.  
1467 D: We talk on the phone a lot and she's very  
1468 involved with my children =  
1469 MW: = yeah =  
1470 D: = and my life =  
1471 MW: = \*right.\* So so how many in your family  
1472 you are one of how many? =  
1473 D: = I have two sisters.  
1474 MW: And where are you in the line up? =  
1475 D: = middle =  
1476 MW: = you are number two (.) okay (.) \*okay\*  
1477 ((writing notes)) (1.7) so um: your mom is

1478           hearing this now you (reckon) some things  
 1479           that she will know intuitively but there were  
 1480           some pretty important developments in  
 1481           your life =  
 1482   D:       = aha =  
 1483   MW:     = in last few months or so?  
 1484   D:       Yeah I don't know if \*she\* (.3) yeah I think  
 1485           she's noticed some changes because she  
 1486           made some comments =  
 1487   MW:     = yeah? =  
 1488   D:       = about some things that I was doing that I  
 1489           hadn't done before =  
 1490   MW:     = can you tell me about those comments? =  
 1491   D:       = um (1.5) well that I am >you know< I've  
 1492           been much more relaxed about um (1.1)  
 1493           entertaining in my house like having family  
 1494           for dinner and having people over. It's  
 1495           much easier for me than it used to be. =  
 1496   MW:     = yeah yeah =  
 1497   D:       = umm (1.9) >and and< she's commented  
 1498           on that (.3) we didn't go into any discussion  
 1499           about it (.6) but I did (bring out) that it's  
 1500           more fun than it's used to be \*you know\* I

1501 don't feel as (.9) \*hassled\* um I didn't feel  
 1502 so comfortable (1.4) \*yeah\* when I was  
 1503 married it was ((laughs)) I spent so much  
 1504 emotional energy being angry that (.7) now  
 1505 I am freed of that and =  
 1506 MW: = right =  
 1507 D: = there was emotional injury and other  
 1508 things that are more creative.  
 1509 MW: Okay so (.5) so what is that reflect you  
 1510 think? The fact that you you said reflects  
 1511 (partly) that you are now separated that  
 1512 made it easier for you to be relaxed and =  
 1513 D: [I think  
 1514 MW: = less hassled and easier without [this =  
 1515 D: [yeah =  
 1516 MW: = how?  
 1517 D: = and just be myself more I mean I feel like  
 1518 I'm (.6) I can I'm expressing who I am so  
 1519 much more than kind of being (.5) tied so  
 1520 much with this other person and wondering  
 1521 whether what I am doing is satisfactory to  
 1522 him and =  
 1523 MW: = oh I see \*yeah\* =

- 1524 D: = so there is kind of a freedom in that =
- 1525 MW: = right okay so um (1.0) that helps me
- 1526 understand so it made a lot easier for you to
- 1527 be who you are (.8) and: just being with
- 1528 people and (.8) um =
- 1529 D: = uh-huh =
- 1530 MW: = not >not< um sort of having to fit with
- 1531 certain expectations about who you should
- 1532 be [or something like that, is that it?
- 1533 D: [yeah] and just >just< the mechanics of
- 1534 the home life =
- 1535 MW: = yeah =
- 1536 D: = needing help with the children and =
- 1537 MW: = yeah =
- 1538 D: = maybe some times getting it some times
- 1539 not or you know whatever [it was =
- 1540 MW: [yeah
- 1541 D: = it's easier for me to just do it myself and
- 1542 not be annoyed because somebody else is
- 1543 not helping me [out kind of thing =
- 1544 MW: [yeah
- 1545 D: = but um (2.9) I don't know I just feel more
- 1546 open to and I really enjoy (1.5) having the

- 1547 people around me and my family we are  
 1548 very close family =  
 1549 MW: = \*uh-huh\* =  
 1550 D: = and um that's really important to me =  
 1551 MW: = right so that's >that's< more valuable to  
 1552 you that sense now than it was? =  
 1553 D: = no my family has [always been important  
 1554 to me =  
 1555 MW: [always been  
 1556 D: = but I feel like I can enjoy them more >in  
 1557 my own home< =  
 1558 MW: [yeah  
 1559 D: = that's the difference opening up my home  
 1560 to [them.  
 1561 MW: [yeah so (you're free)  
 1562 D: [that feels really good you know =  
 1563 MW: [okay.  
 1564 D: = really been conscious of trying to have  
 1565 >you know< establishing new rituals for me  
 1566 and children around holidays and =  
 1567 MW: = yeah? yeah? =  
 1568 D: = doing different things that we didn't do =  
 1569 MW: = What sort of rituals? =

1570 D: = Well we decorate the house for all the  
 1571 holidays =  
 1572 MW: = yeah? =  
 1573 D: = and make cookies for >you know< like  
 1574 we did Valentine's cookies in shapes of  
 1575 hearts and we wrote everyone's name on  
 1576 them on Valentine's day and we um (.9)  
 1577 What else did we do? What did we make  
 1578 the other day for Purim? ((looking at  
 1579 Mathew)) We had a Jewish holiday the  
 1580 other day we made hamentashen.  
 1581 M: (inaudible)  
 1582 D: [with cream on it for Jewish holiday  
 1583 A: ((coughing))  
 1584 D: ughh! and um just you know =  
 1585 M: [(inaudible)  
 1586 D: = as each holiday kind of like being aware  
 1587 of the seasons and okay like (.7) Hanukah  
 1588 time is over we decorate for New Years and  
 1589 we make >you know< a big (thing) of =  
 1590 MW: [yeah yeah  
 1591 D: = so we just have new family rituals that are  
 1592 just ours.

- 1593 MW: = yeah =
- 1594 D: = so that's really nice =
- 1595 MW: [that's great that's great
- 1596 D: ye::ah. =
- 1597 MW: = and um (.5) and the children enjoy the
- 1598 rituals too I guess?
- 1599 D: You know we involve Andrew in as many
- 1600 family things as we can =
- 1601 M: [(inaudible)
- 1602 D: and he likes having a lot of people around
- 1603 him so I know he enjoys that. And Mathew
- 1604 is >you know< he is learning with all these
- 1605 new things I want him to look forward to
- 1606 (.5) the holidays and when he remembers
- 1607 about the last time we celebrate it =
- 1608 MW: [\*yeah\*
- 1609 D: = so (.) yeah I think he is enjoying it.
- 1610 MW: (1.4) So it's quite a different atmosphere
- 1611 generally in home \*in your home life.\*
- 1612 D: [yeah
- 1613 MW: Can I get back to this discipline >you
- 1614 know< are you surprised that to (1.0) um
- 1615 (.5) you know acknowledged the fact that

1616           you are refusing to be (.9) um (.9) so  
 1617           disciplined or? is that surprise to you? or  
 1618           isn't? =  
 1619   D:       = ((nodding)) it is a surprise to me.  
 1620   MW:                               [>yeah yeah<  
 1621           How come that it is surprised to you? that=  
 1622   D:       = um (5.5) \*why is that surprise? These are  
 1623           interesting question why?\* =  
 1624   MW:                               [>yeah. yeah. yeah.<  
 1625   M:       [(inaudible)  
 1626   D:       = um (1.0) I don't know cause I guess I'm  
 1627           so used to being one way um  
 1628   MW:                               [yeah  
 1629   D:       (1.9) It's just (2.1) I think because fear kept  
 1630           me (.5) kind of contained =  
 1631   MW:       = \*right okay\* =  
 1632   D:       = >and and< um (1.7) and it's only in  
 1633           looking back at the process beginning to  
 1634           change that surprises me while it was  
 1635           happening (.7) um (1.5) maybe I am not as  
 1636           aware of it as (it's) beginning to happen. =  
 1637   MW:       = This is fear of? =  
 1638   D:                               [(ugh ohh)



- 1639 MW: = of upsetting someone or?
- 1640 D: = yeah >no you know< I had a lot of years  
 1641 of being really disciplined about food and  
 1642 [eating =
- 1643 MW: [(ohh okay)
- 1644 D: = and um and I think a lot of that was just  
 1645 fear of (.) expressing myself of who I was =
- 1646 MW: [right
- 1647 D: as a woman and >you know< whatever  
 1648 other capabilities (.4) all the other  
 1649 capabilities that I have =
- 1650 MW: = right =
- 1651 D: = and just kind of letting (.2) some of that  
 1652 go um [it's scary =
- 1653 MW: [right yeah >yeah<
- 1654 D: = and yet it feels like (.5) I'm kind of being  
 1655 more like a participant in life (than before)=
- 1656 MW: So this fears would have you do what?  
 1657 What sorts of things would these fears have  
 1658 you doing that can't get you to do now you  
 1659 know? =
- 1660 D: = um (1.7) well particularly around food  
 1661 just not wanting to be real disciplined about

1662            what I ate and not wanting to (2.0) um >you  
 1663            know< eating only what I was decided I  
 1664            was going to eat that day and that kind of  
 1665            thing =  
 1666    MW:    = right okay =  
 1667    D:      = be really controlled about it =  
 1668    MW:    = \*yeah\* =  
 1669    D:      = >cause I guess it< made me feel like I had  
 1670            some control over my life =  
 1671    MW:    = right I get it. \*yeah\*=  
 1672    D:                            [\*yeah  
 1673    MW:    = \*okay\* all right. >One of the things< that  
 1674            I (.5) I'm gonna ask you couple of more  
 1675            questions then (us) just we'll hear from the  
 1676            team if that's? =  
 1677    D:      = okay fine ((nodding)) =  
 1678    MW:    = Are we talking about what you want to  
 1679            talk about or [(inaudible)?  
 1680    D:                            [yeah actually I am aware of  
 1681            saying lots of things that I can't believe that  
 1682            I am saying cause there are people on the  
 1683            other end there [((laughs)) =  
 1684    MW:                            [((laughs))

- 1685 D: = that I know so: ((laughing)) =
- 1686 MW: = What sorts of things are you saying that
- 1687 you can't believe you're saying? =
- 1688 D: = um (.4) well I think talking about (.9) the
- 1689 discipline about that and um about (1.2) the
- 1690 depression that I had and the medication=
- 1691 MW: [yeah yeah
- 1692 M: (inaudible)
- 1693 D: = and that kind of stuff it's very personal =
- 1694 MW: = yeah =
- 1695 D: = and =
- 1696 MW: = Is it okay is it okay with you or? =
- 1697 D: = It is now ((laughs)) yeah it's okay.
- 1698 MW: [\*yeah right\*
- 1699 D: = yeah I think cause part of (.) my growth is
- 1700 being more open >I mean I don't believe I
- 1701 have to tell everybody everything about my
- 1702 life< but being more open about things =
- 1703 MW: = yeah =
- 1704 D: = not keeping so many things to myself
- 1705 MW: (.9) so: (1.0) okay is this something that
- 1706 you could have done like this six months

1707           ago? or twelve months ago? (.) talk so  
 1708           openly about =  
 1709   D:           [I don't know, I don't know, maybe not  
 1710   MW:                   [\*not sure\*  
 1711   D:    = about my children most probably but not  
 1712           about myself.  
 1713   MW:   You know: um (.8) so you would be more  
 1714           closed to people about yourself personally?  
 1715   D:    = uh-huh=  
 1716   MW:   = Do you see the increase in openness as a  
 1717           positive thing or negative thing? =  
 1718   D:    = I think it's a positive thing =  
 1719   MW:                   [it's positive  
 1720   D:                               = yeah  
 1721   MW:                               [yeah  
 1722           How does that affect you? you know to be  
 1723           more open in this way? How does it? =  
 1724   D:    = um I think (3.3) it makes me more um  
 1725           (1.8) I don't know (.) it's it allows me  
 1726           closer connections to people I think. =  
 1727   MW:   = \*right\* (.) okay. So changes your quality  
 1728           of your [relationships =  
 1729   D:           [uh-huh

- 1730 MW: = with others =
- 1731 D: = uh-huh =
- 1732 MW: = \*yeah\* was there a certain fear that
- 1733 you've managed to (.5) break free off like
- 1734 in relation to that? like what does this
- 1735 suggest that um
- 1736 D: (.3) a certain fear? =
- 1737 MW: = that there was a certain fear playing some
- 1738 part [
- 1739 D: [yeah (makes me find out) =
- 1740 MW: = [in relation (with others)
- 1741 D: [that I am not perfect or
- 1742 something ((laughs)) =
- 1743 MW: = okay [a fear of being not perfect
- 1744 D: [I mean big surprise!
- 1745 ((Diane and Michael White laugh))
- 1746 MW: (2.3) So this fear that someone might find
- 1747 out that you are not being perfect =
- 1748 D: [yeah =
- 1749 MW: = [would be isolating
- 1750 D: = [I think to be honest >I mean< it has a lot
- 1751 to do with my family and not wanting my

1752 mom and dad to know certain things about  
1753 [me that are personal =  
1754 MW: [yeah yeah  
1755 D: = because it would be extra burden for them  
1756 to worry about it and also just to keep my  
1757 own boundary about (.7) who I am and  
1758 keep that =  
1759 MW: = yeah (.6) yeah. Are you concerned that  
1760 boundary is being broken today? or is? =  
1761 D: = a little bit =  
1762 MW: = is that a concern of yours? =  
1763 D: = a little bit =  
1764 MW: = It is, what are you concern about? =  
1765 D: = um =  
1766 MW: = cause this is a unique situation to have  
1767 your mom [behind the screen  
1768 D: [yes it is.] It caused me some  
1769 anxiety we talked about a little bit =  
1770 MW: [\*yeah yeah\*]  
1771 D: = um (3.6) well I think you know in regards  
1772 to specially when I talked about the  
1773 medications [is something I've never =  
1774 MW: [yeah

- 1775 D: = told her =
- 1776 MW: = right =
- 1777 D: you know and and because I want it
- 1778 because it was real important that it just be
- 1779 my own personal thing =
- 1780 MW: = yeah =
- 1781 D: = and I don't >you know I don't want to
- 1782 discuss it< =
- 1783 MW: = right okay =
- 1784 D: = it's like it's my own (.8) personal world =
- 1785 MW: = yeah (1.2) so: um. How can we attend to
- 1786 this concern like here today like your
- 1787 concern could have certain effect on your
- 1788 relationship with your mom or (play)
- 1789 direction with you? =
- 1790 D: = um (.) well I don't know that I am
- 1791 concerned to have direct specific
- 1792 relationship effect on my relationship um
- 1793 (.3) it's just um (.) it's just the process of
- 1794 exposing [myself =
- 1795 MW: [yeah yeah
- 1796 D: = it's kind of uncomfortable =

1797 MW: = yeah ((nodding)) okay is there any way  
 1798 that I could attend to that (.) that we could  
 1799 attend to this discomfort? =  
 1800 D: = maybe we can bring her in too =  
 1801 MW: = maybe she will come in.  
 1802 D: yeah =  
 1803 MW: = okay I wonder if she'll come in =  
 1804 D: = okay =  
 1805 MW: = \*yeah\* (.6) your mom's name is?  
 1806 D: Dorothy.  
 1807 MW: Dorothy. That's right. \*yeah\* (2.5) I  
 1808 wonder if Dorothy could come in?  
 1809 ((White's looking at the mirror while  
 1810 asking)) ((door opens and Dorothy comes  
 1811 in))  
 1812 MW: Hi Dorothy. Would you like to come in and  
 1813 join us?  
 1814 Do: Sure.  
 1815 M: Dorothy there is a great movie! =  
 1816 Do: = There is a great movie?  
 1817 D: ((Diane and Michael are laughing)) Mathew  
 1818 is making a great movie ((laughs)) =  
 1819 MW: [((laughs))



1820 D: = This movie (starring) Mathew. We are  
 1821 calling it Mathew meets Michael.  
 1822 M: (we are so (inaudible) it's called)  
 1823 ((Mathew's reading his book))  
 1824 ((5.0)waiting for the recording team to give  
 1825 Dorothy a microphone))  
 1826 MW: I am really glad that (.) you suggested that  
 1827 Dorothy come in =  
 1828 D: = uh-huh =  
 1829 MW: = yeah (.) and I guess yo:ur interested in  
 1830 Dorothy's response to this or? =  
 1831 D: = I am ye:ah just maybe  
 1832 MW: = \*yeah\* I would be interested in your  
 1833 response as well. =  
 1834 Do: = response to her taking medication? =  
 1835 MW: = well [what ((asking Diane))  
 1836 D: [just this whole thing =  
 1837 Do: = I think as far as that I've noticed that she  
 1838 is feeling so much more upbeat and hopeful  
 1839 and we spoken about it and I am glad if  
 1840 that's what doing it we have been glad to  
 1841 see changes =  
 1842 MW: = yeah =

- 1843 Do: = with her =
- 1844 MW: = yeah yeah =
- 1845 Do: = especially these past few weeks=
- 1846 MW: [\*yeah\*
- 1847 Do: = and it's (.7) it's been >feeling really
- 1848 good< and (.) if it's part of her perspective
- 1849 and her hope and with the medications
- 1850 that's great =
- 1851 M: ((Mathew is moving around and talking
- 1852 (inaudible) while Dorothy is talking))
- 1853 Do: = that's great. I wouldn't have asked her it's
- 1854 that we you know speak about it and we
- 1855 just want everything so good for her. (3.4)
- 1856 She is very special.
- 1857 MW: (1.5) I can understand that.
- 1858 D: Shhhh be quite ((telling Mathew))
- 1859 MW: What are you thinking about right now? =
- 1860 Do: = I'm just thinking that I want everything
- 1861 good (.7) and wonderful for her (.9) and
- 1862 whatever process she goes through
- 1863 therefore to be good (1.8) is alright. =
- 1864 MW: = yeah =
- 1865 M: (do you try movies?)

1866 Do: Come sit over here. ((telling Mathew))

1867 MW: (1.2) So you really (inaudible) things =

1868 Do: = absolutely absolutely ((nodding))

1869 MW: Is there some problem \*with this thing\*?

1870 ((asking cameraman))

1871 C: \*no okay sorry\*

1872 Do: put it down ((saying to Mathew who sits in

1873 her lap)) so that I can see Michael's face =

1874 MW: = so that's what you are thinking about =

1875 Do: = yeah \*yeah\* I know she's been in a lot of

1876 pain and I always want to fix it but you

1877 can't fix all the pain =

1878 MW: = yeah.

1879 Do: (1.8) and um (.6) I think some of the things

1880 yeah that she said is not a surprise \*to me\*

1881 and I'm certainly aware that there are times

1882 (.5) I just don't say it I don't want to

1883 impinge upon her own privacy and her own

1884 boundaries because I do respect (.5) I have

1885 a great deal of respect of her as a person. =

1886 MW: = hmm =

1887 Do: (2.4) and you know I hope that >you

1888 know< whatever she needs we are there for

1889 her certainly (1.1) and I certainly know that

1890 she feels open to that.

1891 MW: (1.3) Do you want to say anything to your

1892 mom about the concerns you had about? =

1893 D: = um (.9) ye:ah well it's hard for me >you

1894 know< it's like I think (1.0) what I wanted

1895 to =

1896 A: [((Andrew is coughing))]

1897 D: [ughhh] ((looking at Andrew))]

1898 = look I am really awa:re in my relationship

1899 to you that I kind of like (.3) let you all the

1900 way in and sometimes put up wa:lls =

1901 Do: = uh-huh =

1902 D: = that's not okay now and I know that it

1903 must be really hard [for you::

1904 Do: [sometimes it gets a

1905 little confusing.

1906 D: I know but it's like sometimes um I guess

1907 it's just whatever sometimes I just need that

1908 privacy and I think (.3) one of the reasons I

1909 was concerned about (.) the medication is

1910 that I didn't want >like I didn't want< to

1911 talk about it (.8) um >you know< like with

1912 the kids sometimes we talk about it and  
 1913 [stuff and =  
 1914 Do: [uh-huh uh-huh  
 1915 D: = you do some research and I really needed  
 1916 that to be [really private  
 1917 Do: [uh-huh  
 1918 D: = so: that was my concern [about =  
 1919 Do: [yeah  
 1920 D: = not telling you. =  
 1921 Do: = I can understand that. =  
 1922 D: = not that I didn't think that you suspect it  
 1923 ((laughs)) because ((laughs))  
 1924 Do: = I really didn't suspect it I just thought  
 1925 that you just looked [so good lately you  
 1926 D: [blossomed  
 1927 Do: = [you blossomed  
 1928 D: = [because of the dates I had (laughs)  
 1929 Do: I thought that was it! but to be able to do  
 1930 that and go out and you just looked more  
 1931 upbeat you know we spoken about that you  
 1932 just have more ("jeune devire") you know  
 1933 it's just been so good you know to see that.  
 1934 \*You know\* these past few weeks and if

1935            that's what helped that's great. You know I

1936            (.) send people for medication and I find

1937            that I see you know differences and I am

1938            certainly a believer in it >you know to an

1939            extent< and =

1940    MW:    = it might be part of the story but it's only

1941            part of the story =

1942    D:       = you know for me it's a significant part of

1943            the story =

1944    MW:    = right =

1945    D:       = not the effects of it but just my

1946            willingness to say I can't do this alone and

1947            to reach out for [whatever =

1948    MW:                            [right okay

1949    D:       = I needed

1950    MW:    [so that was a pretty yeah

1951    D:    [yeah

1952    MW:    Was that sort of getting away from this (.9)

1953            disciplining of yourself as well \*in a way or

1954            like\*? =

1955    D:       = yeah like I can do this myself

1956    MW:    [yeah

1957    D:       = or that um

1958 MW: [so the act of (self) was significant=  
 1959 D: = yeah and realizing that hope had limits =  
 1960 MW: = yeah okay =  
 1961 D: = \*yeah\* ((nodding)) =  
 1962 Do: = I think some of it is (2.2) and I guess it  
 1963 certainly (steams) back a lot from me  
 1964 thinking that Diane can always do anything  
 1965 that she ever wanted to do and I think it's  
 1966 too much of a burden to put upon anybody  
 1967 (.6) >you know as a parent< because (.) she  
 1968 was always just so present and there and  
 1969 interested and bright and certainly always  
 1970 took leadership roles you know even as a  
 1971 very young child and saying to someone oh  
 1972 you can do whatever you want and (.4)  
 1973 that's you know I realized that now that's  
 1974 too much to say to anybody because then  
 1975 you have to keep living up to it and doing  
 1976 that (.6) and that can be a hardship.  
 1977 D: It's hard to say perfect thing when your  
 1978 parents are always right ((laughs)) =  
 1979 Do: = That's true. =

1980 MW: = Has you mom um (.9) done anything to  
 1981 contribute to you actually breaking free of  
 1982 these expectations as well? I think mom is  
 1983 (inaudible) but is she also =

1984 D: = yeah I think so because there was always  
 1985 a sense of having to (.3) live up to some  
 1986 expectations that my mother has of me and  
 1987 so in her (.) um it's been a lot of (.4) times  
 1988 when I and I was very open and sharing  
 1989 how difficult at time that was for me this  
 1990 past summer and (.2) her support of me and  
 1991 her ability to >you know< her saying (2.4)  
 1992 acknowledging the limits was really  
 1993 important like a real relief  
 1994 [like oh I don't have to be! =

1995 MW: [so your mom's acknowledgment of the  
 1996 fact =

1997 D: = yeah I don't have to be you know  
 1998 sometimes it is a pressure well (.) Why  
 1999 don't you do that? Why don't you do that?  
 2000 Is like HA maybe I have to do that, but just  
 2001 the recognition that there are some limits



2002           and that she acknowledged them was (.4)

2003           pretty significant.

2004   MW:   So this (hope feels) like there is always lots

2005           of gaps that I am always interested in when

2006           I am talking with people and this (hope)

2007           fills the gap a little bit for me =

2008   Do:    = uh-huh =

2009   MW:   = and I am starting to find out about what

2010           your contribution has been to your daughter

2011           you know daughter's refusal to be so

2012           disciplining of herself, is that correct in a

2013           way? =

2014   D:    = uh-huh yeah =

2015   MW:   = your mom has played a role in it (.6) and

2016           how did she? =

2017   D:    = Not that I think she played a role in

2018           making me so disciplined ((laughs)) but =

2019   MW:   = yeah yes both =

2020   Do:    = ((nodding)) certainly retrospectively one

2021           can look back and (give her a) smart =

2022   MW:   = yeah yeah we can always be wise (in

2023           down sight) =

2024   Do:    [absolutely absolutely

2025 MW: = I don't think we I don't think give any of  
 2026 us is that being wise in (forth sight).

2027 D: Yeah we don't know exactly what to say in  
 2028 front \*to do that that would be nice\* =

2029 MW: = So what is your mom said or done that's  
 2030 contributed to you (.5) this refusal to be so  
 2031 disciplined and some of the other things  
 2032 that we were talking about?

2033 [inaudible (expectations)]

2034 D: [Said or done?] God I don't think that I can  
 2035 think of specific things

2036 MW: [what worked?]

2037 D: you know well (1.5) >you know< I think  
 2038 just an acceptance which is been so  
 2039 important to me (1.0) you know the  
 2040 difficulty that I've been going through  
 2041 particularly around my separation =

2042 MW: = yeah =

2043 D: = and concerns about the children (.8) just  
 2044 getting on the phone with my mother she  
 2045 does listens to me the only person in the  
 2046 world I don't have to pay you know she  
 2047 does listen to me ((laughs)) =

2048 Do: ((smiles))

2049 D: = and that's so valuable to me (.) I don't

2050 mean it cynically as it sounds. ((laughs))

2051 Do: ((nodding and smiles))

2052 MW: Did you >did you< were you aware that

2053 you played some role in in (that)? =

2054 Do: = I certainly know that I play a role in my

2055 children's lives =

2056 MW: = yeah =

2057 Do: = you know to know to what extent I think

2058 a parent really doesn't always know to what

2059 extent (.2) and I hope that Diane knows that

2060 I'm always there even if it's telephone call=

2061 MW: = I guess I was meaning specifically did

2062 you know that you played some role in

2063 helping Diane to (.9) enter into this refusal

2064 of disciplining herself so much and to (.)

2065 challenge the [expectations =

2066 Do: [no, not really

2067 MW: = change her the relationship with hope?

2068 Do: [not really =

2069 MW: = Is it important for you to know? =

2070 Do: = It is important to know that. =

2071 MW: = It is =  
 2072 Do: = and it is also >you know< important to  
 2073 know she got referred to you before and in  
 2074 like doing her own rituals and having things  
 2075 in her own home when in the past >you  
 2076 know< I have done it \*you know\* I am  
 2077 mom and everybody comes to mom's house  
 2078 and I do everything and I try to do the best I  
 2079 can (.4) and the fact that she is wanting to  
 2080 do it and so well =  
 2081 MW: = yeah =  
 2082 Do: and it's been (.3) so warm and caring =  
 2083 MW: = \*yeah\* =  
 2084 Do: = and um it's so good for me to see you  
 2085 know to see her doing that and I know that I  
 2086 backed off if she says come to my house  
 2087 and we are doing something. We are having  
 2088 this holiday party and um (.9) I don't have  
 2089 to say I'll do it =  
 2090 MW: = right okay =  
 2091 Do: = when in the past I would say oh don't  
 2092 bother I'll do it now =

2093 D: = but what's important to me is interesting  
2094 how it started because it used to be I was so  
2095 overwhelmed with having the whole family  
2096 in my house and with Andrew and Mathew  
2097 and trying to have everything done (.) but  
2098 the family said let's do it in a way that's  
2099 easiest for you Diane =

2100 MW: = yeah =

2101 D: = and the easiest thing for me turned out to  
2102 have it in my own home. I don't have to  
2103 bring Andrew and they said we'll bring the  
2104 food (.) Was it thanksgiving? We'll bring  
2105 the food and I said fine ((laughs)) I'll set  
2106 the table (.) but I mean just that (2.0) just  
2107 that (.) concern of making it easiest for me  
2108 and allowing me to make it easy on myself  
2109 because I always try to do things that I  
2110 thought was supposed to be done =

2111 Do: [for everybody else

2112 D: = for everybody else that was like worst for  
2113 me =

2114 MW: = \*yeah yeah\* =

2115 D: = so it's that permission giving >I mean<  
 2116 even at age almost thirty-nine ((laughs))  
 2117 MW: ((laughs)) you are already thirty-nine? =  
 2118 D: = ((laughs)) thanks!  
 2119 Do: [((laughs))  
 2120 D: = not quite >I am only thirty-eight<  
 2121 \*in two weeks I'll be thirty-nine\* =  
 2122 MW: = only thirty-eight ((smiles)) =  
 2123 D: = ((laughs))  
 2124 Do: [((laughs)) (. )  
 2125 M: ((Mathew is playing loudly))  
 2126 Do: want some (air) Mathew? =  
 2127 MW: = we are going [to switch around in just a  
 2128 sec =  
 2129 D: [oh-oh honey, Mathew are you  
 2130 ready to get up now?  
 2131 Do: (I can take him outside) pardon?  
 2132 MW: = he's been really good =  
 2133 Do: = [he has been this is a long time  
 2134 D: [he has been this is a long time for him  
 2135 to sit =  
 2136 MW: = they both are being great actually =  
 2137 D: = yes Andrew you too

2138 Do: [I actually came along to help take  
 2139 care of children =  
 2140 MW: = yeah =  
 2141 Do: = not into the room cause I did respect  
 2142 Diane's privacy and felt that was important.  
 2143 MW: was um (.9) is this something um (.6)  
 2144 Mathew was a bit primed up for this  
 2145 meeting or?  
 2146 D: (.7) Was he what? =  
 2147 MW: = I am just impressed with how Mathew's  
 2148 being in [this meeting  
 2149 D: [he's been excellent terrific he's  
 2150 been very good  
 2151 MW: = I said was he primed up for the meeting?  
 2152 Do: [Diane talked to him this morning  
 2153 D: [We talked about it yesterday that he is not  
 2154 going to school today he is going to meet  
 2155 Michael White from Australia he was really  
 2156 trilled with that =  
 2157 MW: = yeah really? =  
 2158 D: = He called you Michael Jackson a few  
 2159 times but =  
 2160 MW: = Michael Jackson yeah that's okay =

2161 Do: = He called Ronald Regan Ronald  
 2162 McDonalds =  
 2163 MW: (laughs) that's okay too.  
 2164 D: [come on sweetheart  
 2165 MW: So he's been really great =  
 2166 D: = he's been very welled behaved I am very  
 2167 proud of you sweetie =  
 2168 MW: = Do you know why your mom is proud of  
 2169 you? =  
 2170 M: = eh? =  
 2171 MW: = Do you know why she is proud of you?  
 2172 M: ((Mathew's making funny faces and sounds  
 2173 for camera))  
 2174 MW: ((laughs)) (inaudible) because you are so  
 2175 cute? ((laughs))  
 2176 D: ((kissing and hugging Mathew)) smart boy  
 2177 can I wipe your nose?  
 2178 MW: Can I just say quickly =  
 2179 Do: = yes =  
 2180 MW: = before we turn around (.) just to get some  
 2181 (.3) we've been talking about things  
 2182 generally and some other questions that I  
 2183 would ask but I'm not going to because of



2184 the time situation I am interested in  
2185 interviewing you about um (.9) a little bit  
2186 more um (.3) because um Diane (.) is a little  
2187 surprised that she is actually achieved what  
2188 she has in terms of refusing to be so  
2189 disciplined um reforming revising her  
2190 relationship with hope challenging the  
2191 expectations so that they don't stretch her  
2192 (1.0) put her in a (limb) like they did and  
2193 number of other developments. But I was  
2194 gonna ask you whether you were surprised  
2195 that she achieved this (.) and if you are  
2196 surprised I would be interested in talking  
2197 with you about that and if not I would be  
2198 interested in you telling some story about  
2199 your daughter that would give us a bit of an  
2200 idea of what sort of foundations that she  
2201 was standing on in order to make it a  
2202 business to change the shape her life in a  
2203 way that she has (.4) in recent times but (.7)  
2204 I don't know if you have any immediate  
2205 response to that?

2206 Do: (2.3) the surprise about discipline because I  
 2207 did not realized that's what she was  
 2208 working on =  
 2209 MW: = yeah =  
 2210 Do: = that was a surprise =  
 2211 MW: = yeah =  
 2212 Do: = that was not what I thought =  
 2213 MW: [yeah yeah  
 2214 Do: = what she was working on. =  
 2215 MW: = right.  
 2216 D: = because I have it's true I have seen her as  
 2217 a disciplined person she has always worked  
 2218 really hard and persevered and having  
 2219 everything you know come out just right  
 2220 and I think >you know< the difficulties that  
 2221 she has had and I think it's her own and I  
 2222 am sure a lot of it is external >you know  
 2223 from us< but her own intrinsic way of  
 2224 wanting to be perfect and thinking that  
 2225 that's what she had to do because that was  
 2226 what's expected of her that she would do  
 2227 that (.3) and um (.2) I am sure >you know<  
 2228 that at many levels >you know< I gave her

2229 (.6) that (2.1) that that (1.7) that projection  
 2230 that's how she should be: (.) and I >and I<  
 2231 meant it in a positive way positive for her  
 2232 and her own self-growth and I guess it has  
 2233 certain >you know< had certain destructive  
 2234 qualities to it you know I can look back and  
 2235 say that and um (.) and but as far as the  
 2236 discipline it's interesting you know it's  
 2237 really interesting and surprising to me that  
 2238 that's what has helped her right now in  
 2239 moving ahead and forging ahead you know  
 2240 with her own growth =  
 2241 MW: = Are there any time in Diane's life with  
 2242 you you ever experienced her um (.9)  
 2243 (raveling) in imperfection? Can you ever  
 2244 recall a time when Diane was imperfect? =  
 2245 D: ((laughs))  
 2246 MW: = when she seemed (in revenant in that)  
 2247 \*can you?\* =  
 2248 Do: = well she would get herself in a corner a  
 2249 lot =  
 2250 MW: = would she? =

2251 Do: = and couldn't get herself out I mean that's  
2252 we always said that she works so hard to do  
2253 something or get herself entangled in the  
2254 corner was there and needed to walk out  
2255 >you know< two steps from it and couldn't  
2256 see it. So you know that's certainly is  
2257 (\*sign of imperfection\*) =  
2258 MW: = Could you ever imagine yourself  
2259 (reveling) in imperfection? =  
2260 D: = I can image it =  
2261 MW: [you can imagine it  
2262 D: = yeah sounds like a really fun thing to do  
2263 ((laughs)) =  
2264 MW: = yeah? I was just wondering (.4) um I am  
2265 not going to ask you to imagine how you  
2266 might do that at this point (.4) but if you  
2267 were to (reveling) in imperfection and  
2268 experienced um applause from your mom  
2269 in relation to that >or not applause< but just  
2270 really appreciation for that (.) would that  
2271 make a difference to you?  
2272 D: um (1.5) hmm =

2273 MW: = applause was not the right word because  
 2274 that's bit like =  
 2275 D: = yeah like a performance =  
 2276 MW: = yeah like being perfect I didn't mean  
 2277 perfect I mean perfection you know um but.  
 2278 D: (1.0) I don't know I would have to think  
 2279 about that. I mean I know giving myself I  
 2280 just know in small ways how recently I've  
 2281 kind of said (.) oh this is not perfect and  
 2282 that's oka:y and that's great you know =  
 2283 MW: [yeah  
 2284 D: = I can think of small things =  
 2285 MW: = that's on a way isn't it? =  
 2286 D: = yeah =  
 2287 MW: = yeah \*okay\* (.8) Anyway I won't ask you  
 2288 to answer that question right now because  
 2289 we are running we have pretty tight time  
 2290 schedule =  
 2291 D: = okay =  
 2292 MW: = so we are going to hear from the  
 2293 reflection team now =  
 2294 D: = yeah.  
 2295 ((Reflecting Team Part without Michael White))

2296 W1: I'll tell you that um (.8) it's I suppose I  
2297 should see being surprised that the world  
2298 prevents \*you know\* these kinds of what  
2299 seems like coincidences when you  
2300 experience what I had. um um I became  
2301 interested in this field as a result of having a  
2302 child (.5) who was profoundly retarded at  
2303 age four and a half and so (1.4) Diane's  
2304 (1.2) curiosity about how other people cope  
2305 with was one of my motivations too. I  
2306 started working with school kids after my  
2307 daughter got (.9) my second daughter and  
2308 um (1.8) started to see how much families  
2309 were needing attention. The kids needed  
2310 every minute every second they were  
2311 getting but I can see how much families  
2312 were needed and instead of working  
2313 directly with the children who were  
2314 handicapped and had different I moved into  
2315 working with families also so I am really  
2316 quite moved at that other someone else has  
2317 taken a path like this in this work. =

2318 M1: = and that's had a strong influence on your  
 2319 professional life too?

2320 W1: Well it's (.hhh) what how I got to be here  
 2321 um (1.6) I have been (2.2) I never thought  
 2322 about that question before. What is >you  
 2323 know< I don't work most of the time with  
 2324 families who have children who are \*you  
 2325 know have\* these kinds of issues I moved  
 2326 more into working with couples and people  
 2327 who are afraid um =

2328 M2: = this just coming from um >you know< a  
 2329 position some personal knowledge around  
 2330 you know Diane's situation I don't know if  
 2331 there was anything about her that struck  
 2332 you in particular or just you know sort of  
 2333 just coming from you also (your) position  
 2334 um (.5) is there anything?

2335 W1: (1.2)Yes now that you asked me um (.6) um  
 2336 her humor um her easiness with both boys  
 2337 um struck me that something I've seen and  
 2338 haven't thought of it just until you asked  
 2339 me that question about um how was it that  
 2340 that I could do you know work with a child

2341 and have children and one who was  
 2342 profoundly handicapped and it was people  
 2343 would say ugh isn't that hard? And I go (.9)  
 2344 well yes no yes it's just as hard as you think  
 2345 it is no it's not because it's just what I do I  
 2346 just get up and do it >you know< so I was  
 2347 really touched by the easiness and humor =  
 2348 M1: = I was really impressed with (1.2) what's  
 2349 she is juggling and how well she is doing it.  
 2350 I was reflecting of my own experiences in  
 2351 graduate school which in itself was so  
 2352 physically and emotionally stressful for me.  
 2353 It was one of hardest time for me really =  
 2354 M3: = Is that about what she said how people  
 2355 coped? =  
 2356 M1: = yeah and I mean on the top of that she's  
 2357 dealing with two kids and kids that are  
 2358 particularly challenged and I (.7) was really  
 2359 impressed in light of my own experience  
 2360 with just challenged of graduate school  
 2361 itself.  
 2362 M2: I'll just go next and I've listened to a lot of  
 2363 women who I worked with explain to me



2364 some of their experience and \*you know\*  
 2365 I've heard >over and over< women talking  
 2366 about how they sort of being systematically  
 2367 recruited into sort of lifestyle of (.5) being  
 2368 for others and sort of restricted disciplines  
 2369 and sort of life of (itself make life). I was  
 2370 very impressed by Diane (1.3) and her  
 2371 (.hhh) some of the things that she described  
 2372 that (.8) she's a >you know< she's in some  
 2373 instances in recent times she refused to  
 2374 some of discipline invitations. She >she<  
 2375 seems to experiment a little bit in terms of  
 2376 delegating responsibility around issues with  
 2377 the kids with some limited success I  
 2378 understand. (1.7) And this idea that she  
 2379 seems to making use of it seems useful to  
 2380 her to sort of bringing herself in the world  
 2381 more um I find it it was very interesting to  
 2382 me um and I guess one question that I had  
 2383 about it was (1.7) >you know< how might  
 2384 sort of the shift that she seems to be (1.1)  
 2385 um you know undertaking in her life (.)  
 2386 how might this shift invite others to sort of

2387 notice her in new ways (.) and to be for her  
 2388 as she seems to be embarking on a road of  
 2389 >you know< balancing her life between  
 2390 being for others and being for herself.  
 2391 ((nodding))

2392 W1: I am interested in that notion of her of what  
 2393 you were saying about how might that  
 2394 encourage other people to be (1.0) for her  
 2395 (4.1) um I wondered if the Thanksgiving  
 2396 thing was an example of that (.8) where  
 2397 instead of her doing it herself (1.2)  
 2398 everyone said well let's make it easy on  
 2399 you and she oh the easiest would be to have  
 2400 it in my house so we'll bring the food and  
 2401 so and so, I wonder is that the thing you  
 2402 were thinking of? =

2403 M2: = yeah, I think so. I think so and as you  
 2404 were saying that I'll just tag one of the idea  
 2405 onto because this is strictly based on my  
 2406 experience you know listening to to women  
 2407 talk to me (.5) but one of the things that  
 2408 they describe that makes such a sort of  
 2409 admirable you know big undertaking is that

2410 >you know< often when they sort of (1.0)  
2411 separate from you know um these  
2412 disciplines that restrained them or often  
2413 when they sort of undertake this um  
2414 endeavor of being for themselves (.9) guilt  
2415 has a way and as Michael point out  
2416 expectations have a way of trying to sort of  
2417 throw her back you know into a self-neglect  
2418 position. And I wonder >I don't know if  
2419 this applies to her or not< but if it does the  
2420 question I have would be: I wonder if she  
2421 has any experience of (.5) sort of you know  
2422 maneuvering around what guilt might have  
2423 in mind or =  
2424 M1: = yeah I had a thought in relation to what  
2425 you said David in terms of (.9) being  
2426 familiar with ah trying to do things all by  
2427 herself and really being new in a sense to  
2428 relying on others and reaching out to others  
2429 (.7) um and she has quite a community that  
2430 she seems to have reached out to in terms of  
2431 the physical therapist the doctors and the  
2432 support group and her husband and her

2433 mother and I am sure other people are  
2434 involved as well. And I was wondering if  
2435 this community that she's helped built in a  
2436 sense had a voice what would it say about  
2437 her participation with her children, what  
2438 would it say about her taking timeout for  
2439 herself, what would be community voice be  
2440 about that? =

2441 M2: = Do you have any fantasies about that?

2442 M1: I don't have a particular image I was just  
2443 curious more of what that would be.

2444 ((knocking on door or window))

2445 W2: I'll talk briefly, I was curious about that too

2446 because when you talked about

2447 thanksgiving and um: >the other people

2448 coming in and bringing the food and that

2449 sort of thing< but I am curious to know if

2450 Diane would asked them how comfortable

2451 they were about having that type of the

2452 relationship with her which seems like a

2453 shift. I am curious what they would say? So

2454 I was following what you said. The other

2455 comment I want to make is (being I am)

2456 language pathologist I've worked with a lot  
2457 of people who had children with disabilities  
2458 which may be extremely challenging to  
2459 them (.6) and I think there is a real  
2460 invitation a >very very< strong invitation of  
2461 being for others in that situation and one  
2462 thing that really stood out for me about  
2463 Diane and thinking back of other people  
2464 I've worked with is when she was talking  
2465 about hope and how she changed her  
2466 relationship with hope. And just personally  
2467 knowing being with others what a difficult  
2468 (task) that is to do to shift that you are  
2469 going to change what was that you intended  
2470 initially and it takes a lot of strength and lot  
2471 of courage to do that and I guess I  
2472 witnessed that in other people so I wanted  
2473 to let her know that I am trying to  
2474 appreciate how difficult that is and also I've  
2475 seen other people go through that but what  
2476 really stood out of that is that she felt  
2477 comfortable as she made each of those  
2478 shifts, she seems now feeling more

2479 comfortable about making each of those  
 2480 shifts which is I think that contributed to  
 2481 that difference in relationship with hope =  
 2482 M3: = yeah that really speaks to her future as  
 2483 well =  
 2484 W2: = It does yeah I wonder about future =  
 2485 M3: = through her past through recognizing the  
 2486 sparkling uniqueness of the struggle of the  
 2487 struggling past through this and what this  
 2488 point toward her future =  
 2489 W2: = uh-huh yeah =  
 2490 M3: = yeah that's \*a nice way to put it\*  
 2491 W1: It's probably good time to go there is so  
 2492 much more to say =  
 2493 M1: = yeah. ((Everyone is standing up to leave  
 2494 the room; the end of reflecting team))  
 2495 ((White with family again))  
 2496 MW: just wonder what do you um any comments  
 2497 about those thoughts or reflections I know it  
 2498 was little distracting for you cause you were  
 2499 pretty [busy  
 2500 D: [um well I >I was listening really <  
 2501 trying to remember what I was thinking

2502           about when I was in there um (.8) I was  
2503           kind of smiling to myself cause one of the  
2504           gentlemen said something about the  
2505           experience of guilt ha ((laughs)) I wrote a  
2506           book on this ((laughs)) =  
2507    MW:                           [(((laughs))]  
2508    D:       = yeah >I mean< because letting go of  
2509           some of the stuff and becoming (1.0) is  
2510           such a process just it's beginning of  
2511           becoming >you know< for myself is so  
2512           hard because I think about (.3) some of the  
2513           questions were who would be least  
2514           surprised and who would be (.2) about you  
2515           know what would community's voice  
2516           would be (.2) I always have this community  
2517           voice in my head like (.4) you know of  
2518           course I do fabulous job with kids and I  
2519           know everybody thinks that's great but  
2520           what they would think about me doing for  
2521           myself that feels >like I am not really  
2522           supposed to do that< so it's kind of trying  
2523           to let go of that =  
2524    MW:       = yeah \*yeah\* =

2525 D: = that's really hard to do.

2526 MW: (1.2) [so that =

2527 D: [maybe I would be so prefect with kids

2528 but maybe I won't be so amazing with

2529 children

2530 MW: ((nodding)) ye:ah

2531 M: ((screaming))

2532 D: Honey wanna sit at mommy's lap? ((asking

2533 Mathew)) ha? We are almost done sweetie=

2534 MW: [So was that?

2535 D: = I know this is hard for you ((saying to

2536 Mathew))

2537 MW: why (inaudible) would be really good yeah?

2538 and (.5) I can understand why your mom is

2539 proud of you \*yeah\* same with Andrew =

2540 D: = Andrew is good boy too =

2541 MW: = um \*any\* normally I would ask few more

2542 questions about that but (inaudible) and um

2543 I think that we should (find this out) fairly

2544 soon >any other do you have any other

2545 thoughts about reflections?< ((asking

2546 Dorothy))



2547 Do: (1.6) I was thinking what I heard some of it  
 2548 I didn't hear very well what they were  
 2549 saying about >you know< also about >you  
 2550 know< the community and expectations of  
 2551 Diane =  
 2552 MW: = yeah =  
 2553 Do: = and um (1.4) and how she would >you  
 2554 know< perceive other >other< how other  
 2555 person would perceive her? And and you  
 2556 know in knowing her I know that she she  
 2557 always works to live up to those  
 2558 expectations of her because everyone says  
 2559 everything you do is so well (.) everything  
 2560 is in order and how do you do it? I am  
 2561 always so amazed by it. I think the more  
 2562 people say that the more pressure it puts  
 2563 upon her =  
 2564 MW: [yeah yeah  
 2565 Do: = and that's a hard one because she  
 2566 internalizes all that pressure because most  
 2567 people don't expect that she would have to  
 2568 do all the things that she does.  
 2569 MW: [right

2570 Do: (2.0) And that's that's certainly is how she  
 2571 internalizes that everyone has that  
 2572 expectation >I think people< are surprised  
 2573 and would not be surprised um (.3) if she  
 2574 falls down on anything or says I can't do it  
 2575 I need help (4.0)  
 2576 D: ((whispering to children))  
 2577 Do: = because people would certainly say she  
 2578 has a handful (.4) but look how great it is =  
 2579 MW: = \*yeah\* (.9) so that's something  
 2580 (inaudible)=  
 2581 Do: [uh-huh  
 2582 MW: = inadvertently people would actually  
 2583 increased expectations that Diane might not  
 2584 have thought so\* just the remarks of that  
 2585 (inaudible) =  
 2586 Do: = yeah and then surprised that she continues  
 2587 to do that and if she says >I can't< I don't  
 2588 feel that yeah it's about time that she said  
 2589 that because she just moves along so well  
 2590 that most people would see her and say >I  
 2591 don't think she has care in the world< =  
 2592 MW: = yeah =

2593 Do: = you know which is just incredible.

2594 MW: We can just stop in just a minute. Normally

2595 I would be wanting to ask more questions

2596 about your experience of reflecting team =

2597 D: = uh-huh =

2598 MW: = but I have just (another) question that I

2599 would like to ask and then we will stop

2600 okay? =

2601 D: = yeah =

2602 MW: = um I just (.5) I was talking to your mom

2603 briefly about (.9) her contribution to (1.2)

2604 challenging discipline and >whatever< and

2605 your mom talked about her contribution to

2606 enforcing yours =

2607 D: [yeah ((smiles))

2608 MW: = was that acknowledgment from your

2609 mom? Was that a positive thing for you? =

2610 D: = yeah yeah it is. Actually to tell you the

2611 truth it opens up possibilities for further

2612 discussions for more conversation with my

2613 mom about that.

2614 MW: For her to acknowledge the part she played

2615 D: [yeah

2616 MW: = and you subjecting yourself to these  
2617 expectations or to be perfect =  
2618 D: [yes  
2619 MW: = or whatever =  
2620 D: Yes.  
2621 MW: I figured that was pretty important =  
2622 D: = it is =  
2623 MW: that acknowledgment (.7) \*yeah\* so: um I  
2624 figured that was a special contribution that I  
2625 experienced from your mom today that sort  
2626 of we didn't get back to at the beginning of  
2627 the session that I would like to explore a  
2628 little bit more cause I figured that's pretty  
2629 important. And I also wondered whether  
2630 um (1.4) um its been an issue for you as  
2631 well Dorothy >you know< in your life to  
2632 challenge (.6) this notion of perfection?  
2633 \*Um\* =  
2634 Do: = In my own personal life? =  
2635 MW: = yeah? =  
2636 Do: = yeah yeah =  
2637 MW: = It's been issue for you as well. =

2638 Do: =yeah. I was always trying to do more and  
 2639 not thinking that I could do it and trying to  
 2640 do it better and surprising myself if I >do  
 2641 do< something and (I am) able to take full  
 2642 credit if someone says you did that really  
 2643 well =

2644 MW: = okay. And if you had a little bit of break  
 2645 through in it as well?

2646 Do: Yeah yeah I think =

2647 MW: = When did you have a break through in  
 2648 that?

2649 Do: (3.1) I would say in recent years =

2650 MW: [in recent years?

2651 Do: = really in recent years. So it wasn't  
 2652 certainly during Diane's growing up days =

2653 MW: = right =

2654 Do: = and certainly >you know< it impacted on  
 2655 her for sure ((nodding)) =

2656 MW: = okay so (.) so you had break through in  
 2657 recent [years um =

2658 Do: [uh-huh

2659 MW: so approximately how old were you when  
 2660 you had that break trough? =

2661 Do: = I am pretty old now ((laughs))  
2662 what [should I say? =  
2663 D: [just a little bit over thirty-nine  
2664 Do: = she is older than I am so (1.1) I would say  
2665 in my late fifties =  
2666 MW: = so you did it in your late fifties =  
2667 Do: = uh-huh =  
2668 MW: = and you did it in your late thirties \*okay =  
2669 Do: = she's ahead of me =  
2670 MW: so I wonder when the next challenge might  
2671 go from there?  
2672 Do: ((laughs))  
2673 D: ((laughs))  
2674 MW: = in early teens. =  
2675 Do: = early teens would be good. ((laughs)) =  
2676 MW: = yeah. I was interested in that as well.  
2677 Because that's something I would also like  
2678 to explore. We won't explore that right now  
2679 because we are really (head up) against the  
2680 time limits but a (.7) I'd like to explore  
2681 what got you recruited into those  
2682 expectations? and (.5) how was it that in  
2683 your late fifties you also refused and (.9)

2684 I'm also wondering about that sort of link  
 2685 >you know< so =  
 2686 D: = I wonder if there is simultaneous letting  
 2687 go of that =  
 2688 Do: = uh-huh =  
 2689 D: = on both our parts =  
 2690 MW: = yeah =  
 2691 D: = because I always had a feeling that um  
 2692 (.8) that my mother was very excellent in  
 2693 what she did >she never really knew it < =  
 2694 MW: = yeah =  
 2695 D: = and so it was she would look at me and  
 2696 think that >you know< I can do some things  
 2697 that she couldn't do =  
 2698 MW: = yeah =  
 2699 D: = and maybe recognizing that she is good  
 2700 enough and prefect enough >is maybe kind  
 2701 of < comes at the same time as mine does  
 2702 maybe is something that happens  
 2703 simultaneously. Listen guys ((saying to  
 2704 children)) =

2705 MW: = So we are going to stop now. (inaudible)  
2706 simultaneously protesting at particular point  
2707 in time =  
2708 D: = Excuse me? =  
2709 MW: = like simultaneous protest at the same  
2710 point in time. It's really interesting to  
2711 explore further >but we are going to stop  
2712 now<. We gonna skip the forth part because  
2713 we just don't have time to do that. (.9) And  
2714 I just would like to say I really enjoyed  
2715 meeting with you =  
2716 D: = Thank you. I enjoyed as well. =  
2717 MW: = and I am really pleased that you come in  
2718 as well  
2719 Do: [Thank you thank you ((shakes hands with  
2720 Michael)) and thank you Diane for letting  
2721 me in because =  
2722 D: = ((shakes hands with Michael)) it's always  
2723 difficult ((said to Dorothy)) =  
2724 MW: = and all the best with rest of your program  
2725 and =  
2726 D: [thank you



2727 MW: = for the three thousand hours of the  
2728 supervision ((smiles with Dorothy)  
2729 D: Do you have an opening in Australia for  
2730 intern? ((laughs))  
2731 MW: [((laughs)) We have a lot of requests  
2732 for that sort of thing =  
2733 D: [I bet you do  
2734 MW: = yeah but shall be fun.  
2735 M: Thank you Michael White ((shakes hands))  
2736 MW: Thank you very much it's been really good  
2737 meeting you.  
2738 M: Thank you Michael thank you fat boy!  
2739 MW: Fat boy? Was he talking about you?  
2740 ((looking at the camera)) ((laughs))  
2741 D: = don't be silly =  
2742 M: (inaudible)  
2743 D: I thought we are going to make it though  
2744 the whole morning without saying that.  
2745 MW: Well we nearly made it.  
2746 M: ((laughing))  
2747 MW: Mathew (.) I've enjoyed meeting with you  
2748 it's been really good =  
2749 M: = I enjoyed ((making faces and sounds))

2750 MW: and Andrew I've enjoyed meeting with you

2751 too Andrew I've enjoyed meeting with you

2752 M: Thank you Michael. Thank you fat boy!

2753 ((laughs))

2754 D: Mathew! (Don't be silly)

2755 MW: Well I would to =

2756 M: [Mr. White!

2757 MW: = I would identify with that a little bit more

2758 last year but I lost a little bit of weight since

2759 then ((smiles)) =

2760 D: ((laughs)) Have you seen this dinosaurs

2761 show? =

2762 MW: = No I haven't. =

2763 D: = but that's what (inaudible)

2764 Do: [he picks those things on the

2765 shows.

2766 MW: ((laughs)) (Shaming) television isn't it?

2767 ye:ah so take this off ((taking of his

2768 microphone)).

2769 C: Thank you.

2770 M: Thank you Michael!

### **Biographical Sketch**

Dragana Ilic was born in Switzerland and raised in Serbia. At the age of 8, she started to play tennis, after not being accepted into a musical school to play the piano. As a tennis player, Dragana won six national championships and competed for the Serbian national tennis team many times, representing her country around the world. She became a professional tennis player at age of 16 and she won several international tournaments in Greece and Italy. While traveling to compete, Dragana visited more than 30 countries and interacted with people from many different cultures. She learned to speak six languages. Since her early age, she often lived and trained away from home, in former Czechoslovakia and Italy, in order to improve her game. As a result of her successful tennis career, Dragana received a full scholarship to play for the women's tennis team at Lynn University in Boca Raton, Florida.

In 2004, Dragana moved to study psychology at Lynn University. She received her Bachelors of Science in Psychology with 4.0 GPA. With her tennis team, she won many conference and regional championships. She was undefeated for two years, and she received many awards, including the MVP and the ESPN award in recognition of outstanding academic and athletic achievement.

After completing her Bachelor degree, Dragana was offered a full scholarship for a Lynn University graduate school, in order to stay and help with coaching tennis team. She received her Masters of Science in Applied Psychology with specialization in Clinical Psychology from Lynn University in 2009. As a graduate student at Lynn University, Dragana presented her research projects at the American Psychological Association Conference in Boston, in 2008, at the Southeastern Psychological

Association Conference in New Orleans, in 2009, and at the Rocky Mountain Psychological Association Conference in Albuquerque, in 2009. Before deciding to pursue her doctoral degree in Marriage and Family Therapy, Dragana was interested in Sports Psychology, Social Psychology, Positive Psychology, and Developmental Psychology.

As a doctoral student in Family Therapy at Nova Southeastern University, Dragana worked as an Institutional Review Board Graduate Assistant for four years. She also had the opportunity to serve as a Teaching Assistant for six masters and doctoral level classes: Introduction to Systems Theories, Theories of Marriage and Family Therapy, Quantitative Research I and II, Thinking Systems, and Narrative Therapy. Dragana presented her doctoral research projects at the International Family Therapy Association XXI World Family Therapy Congress, at Broward Association for Marriage and Family Therapy Workshop, and at the Solution Focused Expo. She was a Supervisor Assistant at the Brief Therapy Institute and at North Side Elementary School.

As a marriage and family therapist intern she worked at Broward Outreach Homeless Shelter, at North Side Elementary School, and at Brief Therapy Institute at Nova Southeastern University. Dragana completed her coursework with 4.0 GPA. She has passed the MFT licensing exam and is currently Registered Marriage and Family Therapist Intern and an AAMFT Approved Supervisor Candidate. She has also assisted in editing articles for The Qualitative Report since 2016. Dragana aspires to work in academia and plans to continue her professional and personal growth.